Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** George William Sraver 2010 3 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square Hospital Rosedale Ba CTIMORE f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Months Hours Min Days 1 🔀 M 2 🗆 F Yrs 214-26-0666 March 7,1930 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Middle River MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 Funeral 126 Lariat Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Ď Specify: 3√□ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Company 12 Years Warehouse Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel P. Turner ဂ္ Frank W. Sraver, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2406 Eagle View Drive Bel Air, Maryland 21015 Mr. Gary Landon (Nephew) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland 3/29/2010 Hilltop Service Corp 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7022 Wise Ave. Dundalk, Maryland 23a. Part . Enter the dease, or shock, or heart Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Due to (or as a consquence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Medical Certification: To

/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran ned by the a s been signed to should be deta Division of Vital Records, page 2 Physician: The

Box 68760

P.O.

or Attending

the Hospital

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If frem 27 is marked other the any Injury or other traumatic event, the once.

**Physician** 

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examiner? 1 ☐ Yes 2 ☐ No	Γ	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 🗆 1	DOA Other: 4	☐ Nursing H	lome 5 Residence	6 Other (Spec	podu	
2 Accident	Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes	2 □No	28d. Describe how inj	ury occurred	Or	fice
	Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, stree ecify)	t, facto	ory, office		28f. Location (Street City or Town, Sta	and Number or Rui ite)	ral Route N	lumber,

29a. Certifier (Check only one)	1 ☐ Certifying Physician: To the best of my knowledge, death occ 2 ☐ Medical Examiner: On the basis of examination and/or investigand manner stated.		
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

Konald ataresio mo

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ess of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, Md

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHANAHAN 6:18 PM JEANNE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MD GOOD SAMARITAH HOSPITAL BALTIMORE CITY BALTIMORE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours 08-08-1928 ar) Marviland 81 213-26-6568 Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medi-al Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No Baltimore Parkville Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21234 3404 Upton Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black. White, etc. 1 Never Married 2 Married <u>\$</u> Yes 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event the status of the status If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Margaret Wilkens Joseph G. Voelker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick S. Shanahan, Sr. - Son Baltimore, Maryland 21234 9707 Oakdale Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 03-30-2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 5305 Harrford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Severe Physician/ End-Stage Chronic Obstructive Pulmonary Medical resulting in death) Due to (or as a consequence of) Disease 8 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a soneequence of): Examin or Attending Physician; The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 1 ☐ Yes 2 № 9 ☐ Unknown the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hon-ST Elevation myocardial infarction 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? Chronic Tobacco Use certificate 2 🗌 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

(tta)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUAKLI - WOSORMU

RE3000

29d. Date signed (Month, Day, Year)

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedents Name (First, Middle, Last) Day **Physician** March 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Baltimore A 9278 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min Year) 1 ☐ M 2 🔀 F 86-0904 3 Yrs. Director MARYIAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Experiment must be retified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Funeral Director TIMORE MRYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Frein AMERICAN ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usg retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cler 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middlé, Last) Be thuR 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship MARGIAN & 1206 eiden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ RemovaMrom State March 29 10 BALLIMORE NARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WANCY M. WALLACE
3405 W. FRANKLIN 21. Signature of Funeral Service Licensee Street-Baltimore Md 2/229 Approximate Interval Between Onset and Death 23a. Part finer the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear fillure. List only one cause on each line. Immediate Cause (Final **Physician** patic Encephalopathy disease or condition resulting in death) /Medical Due to ( )r as a consequence of): Examiner GRECIVS iver Cirrhos Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Dependence coho resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Day Year Month ☐Yes 2☐No 9 Unknown 9 Unknown signed by to detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 1 No 1 ☐ Yes 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Caton Avenue

900

32. Registrar's Signature

Baltimore, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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1	) Examin		4a. Facility Name (if not institution				_	or Location of Dea	ath		4c. County		
نمر	<i>,</i>		Warm Heart 5. Social Security Number	Assistant	Liv	ing		antown			Balt		ontgomery
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<b>′</b> 0	or ite	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed Forces?		If	Yes, specify Cul	oan, Mexican, Pue	erto Rican, etc.)	,		ck, White	
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ary	hould and M is ma		19a. Informant's Name/Relations			19b. Mailin	g Address (Stree	t and Number or i	Rural Route Numb	er, Cit	y or Town, S	State, Zip	Code)
	ealth m 27		Rhonda Allen	-daughter				e Ct Ge	ermanto	_			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 Removal from State	,   00	emetery, crem	sition (Name of natory or other pi		Date	1	c. Location	-	1
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral did	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of g Nurse Practioner: To the	examination	n and/or invest	tigation, in my op	nion, death occurr	ed at the time, date	e and g	place, and du	je to the	cause(s) and manner stated.
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And .	Examin		4a. Facility Name (If not institution, give 57 Rockland Road	street and nu	ımber)		4b. City, Tow					ounty of Death	
mark .			5. Social Security Number 6. Se		7 Ago //p.u	rs. last birthday)	If Under 1 Ye	inste	r er 24 Hrs.	9 Date of Birt	1	arroll	place (State or Foreign
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	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 57 Rockland Road				10f. Zip Cod	21158			10g. Citizei	n of What Cour USA	ntry?
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	P #	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to	(Ui as a CUIIS	equence of).	0.77						JA.
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. 1 h	comb	00 4 y T	openi	a ; -	Ldi	opati	hi c		254
60,	ficate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to	(or as a cons	equence <del>था</del> ):	·	•				į	
98760	ficate phys s the	edical		d									
Box	eath certific attending p for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pre						230	d. Date of deliv	ery
	0 0 0	Physician/M	in the past 12 months? 1 □Yes 2 ANo		birth 2 Fe gnant at time o		Ectopic pregr Other (specif					Month	Day Year
О	lat the d by th	Phys	9 Unknown							OD- Dida		a a médita da da d	he cause of death?
ď,	law requires that the das been signed by the 2 should be detached	þ	Part II. Other significant conditions co	ntributing to d	eath but not r	esuiting in the ui	nderlying cause	given in Pai	rt I.				pably 4 Unknown
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Ř	e las has	dmo								autor		prior to co death?	mpletion of cause of
Vita	i <b>cian:</b> Th certificate ector, pag	ပိ	25. Was case referred to medical					OR DI	an of Doot	1 □Yes		1 □ Yes	2 □No
	Physician: r this certific ral director,	o B	examiner?	Hospital: 1 [	Inpatient 2	☐ ER/Outpatier	t 3 🗆 DOA	Other:		me 5 Resid		□Other (Speci	60
ō	ding Physician: th. After this certifics funeral director, t	-	27. Manner of Death	28a. Date		28b. Time of		injury at Work?		28d. Describe			9)
<u>5</u>	endin sath. or: Af he fur	atio	1 Natural 5 Pending investigation	(1410)	nin, Day, rear,	injury		1 ☐ Yes 2	□No				
DIVISION	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plac build	e of Injury - At ling, etc. <i>(Sp</i> e	home, farm, strecify)	eet, factory, offi	ce		28f. Location (S City or Tov	Street and I vn, State)	Number or Run	al Route Number,
_	spital ours a leral L filled	0	29a. Certifier 1 Certifying Phy	vsician: To th	e hest of my l	nowledge deat	h occurred at th	ne time date	and place	and due to the	cause(s) a	nd manner as	stated
	ne Hos n 24 h ne Fur oletely	edical	(Check only 2 Medical Exam	iner: On the	basis of exam nner stated.	ination and/or in	vestigation, in	my opinion, o	death occur	red at the time,	date and pl	lace, and due t	o the cause(s)
	To the Hospital or Attending Pr within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral process.	M	29b. Signature and title of certifier	1)	1/11		29c. Lic	ense numbe	er A A		29d. Date s	signed (Month,	Day, Year)
			1 Hmw	1m	YUM	m m1)	D	25 4	43	4	3/22	12010	
			30. Name and address of person who o		ise of death (I	tem 23a) (Type,	Print)	/ 1.	la eta	010 070	00	7)	11150
	Sta	te	31. Date filed (Month, Day, Year)	LTON V32.	Registrar's Sig	mature Z	e no	L W	(6711)	1110 216	KII	ے ک	1/3/
	Registr		MAD 9 9 2010	None	was 6	7. DOW	5000						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 1:00 PM M February Earl Sowers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 Dalecrest Court #203
5. Social Security Number | 6. Sex | 7. Baltimore Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday, **Funeral** Year Months 1**№** M 2□ F Jan 26, 235-78-3107 87 1923 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 No Timonium MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 3 Dalecrest Ct; Apt 203 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Specify: white 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl C. Sowers, Sr. Lulu Frances Lee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Sowers/spouse 111 West Rd; Rm 204; Towson, Maryland 21204 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Danie A. Naylor 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) **Physician** oronary 429VG /Medical Due to (or as a consequence of): Examiner Obacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ✓ Yes 2 No 3 Probably 4 Unknown as been si Cance 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed / Yes 2 Mo page After this certificate 1 ☐ Yes 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐Yes 2 ☐No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:07 PM Harch 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai litagited of Bultimore Bultimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Numbe 229-20-49 Age (In yrs. last birthday)
Yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months 20-4929 (Month, Day, Year, Country) Director Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits BAHIMORE 1 Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 15A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 2 No 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced African AMERICAN Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 214 4MERICAN Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a Md. IMONE 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 302010 HRbutus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Street BAITIMORE Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Cerebrovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner days pertension Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted. use as the burial-transi After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed 1 Yes 2 🗌 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES COS Harch 23, 2010 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital 2401 W Belvedese Ave, Baltimore MD 21215 Vu Dany HD Bultimare 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 7/2009

Smith, Walter

KIRWIN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** Floyd Tyler 7:57 p<sup>M</sup> 28 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holly Hill Nursing Home Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 M 2 □ F 73 MD 212-34-4446 Director June 23,36 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at MD Baltimore Towson 1 ☐ Yes 2 👿 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 531 Stevenson Lane 21286 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced er than "natur the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNK UNK UNK UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Florence Wright Charles Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 is or other train B.C. Department Of Aging Towson , Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or oti XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. 3-3-2010 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem. Baltimore 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 2829 Hudson Street Skarda F.H. Baltimore, MD, 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 years Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran Box 68760,4 Due to (or as a consequence of): physician a the burial Physician/Medical attending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ld be detached f P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 1∐ Yes 2 No **Division or Vital** Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

or Attending

within 24 hours after dearn.

To the Funeral Director: f

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

MAR 29 201

29a. Certifier

(Check only one)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Yea Physician/ MÄRCH 23 VELEDNITSKY RAKHIL Рм 9:08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 🗶 F 1273171918 UKRAINE 218-35-0734 91 Yrs. Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the may is marked other than "natural", or items 23a or 28a-1 sho may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10911 BASKERVILLE ROAD 21136 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VELEDNITSKY SAPOZHNIKOVA NUHTM LEAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEEZA SHAPIRO / DAUGHTER 10911 BASKERVILLE ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 📮 Reproval from State 4 □ Donation 5 □ Other (Spedify) 03/26/2010 BALTIMORE HEBREW REISTERSTOWN, MD of Fun alal Servi / Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician d Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate bethin 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 2 Acciden
3 Sulcide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar (Check

only one)

31. Date filed (Month, Day, Year) U.V.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2. Year o Gerald Wallace Carvel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Med. Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. 0471071954 Maryland Director 216-60-6295 55 Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #2 Phyllis Drive 21060 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , 01 Black, White, etc. ģ 1 Never Married 2 Married 2 XNo ☐ Yes 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 
Widowed 4 Divorced Completed Year or Dates Black 27 is marked other than "natur traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 2th Grade Truck Driver Trucking Co Be Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Benjamin Wallace Irma Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other trated one. Glenda Wallace Phyllis Dr., Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest 04/02/10 Hanover, MD <sup>22</sup> Name and Address of Facility own Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the a Unknown 9 Unknown s been signed by the should be detached Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has performed 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MAR 29 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George W. Wright Month ARCH Day 23, 3:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Saint Joseph Medical timore Center 7. Age (In yrs. last birthday) . Social Security Number 243-42-4645 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. **Director** NC19 /193 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 111 West Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🎇 No Black, White, etc XXNever Married 2 Married \$ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) UNK UNK College (1-4 or 5+) UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dept. Of Health 10 N. Calvert St., Baltimore, 21202, MD Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Baltimore, MD Carmel Cem. 3/26/10 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licensee 22. Name and Address of Facility 2829 Hudson Street Skarda F.H. roma Baltimore, MD. . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed PNEUMONIA that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death Yes 2 No signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform certificate has page 1 ☐ Yes 2 X No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Manth, Day, Year) DE4034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wilson, Jr 0. 11:53 AM Joseph 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Balto If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1**2**FM 2□F Months Days Hours Min. 9-16-1930 VΑ Director 231-32-5570 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examinat must be notified at Yes 2 □ No Director MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 2315 E. Preston Street 21213 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 □Yes 2 Ϊ No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Wilson, Sr Anna Bell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other trau Bobbie J. Wilson-Wife 2315 E. Preston Street Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-31-2010 Owings Mills, Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Types MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ulmonavy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Congestive Due to (or as a consequence of): P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by pertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform KIdney Chronic 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State 31. Dat Registrar

31. Date filed (Month, Day, Year)

Hesovah hubon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



R110361

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a per dr.,g901,03/29/2010dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 6.30 AM Manch LOUISE J. WHITEHEAD 010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland 51. Aghes
5. Social Security Number Ballinove HOAPITA N/A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 ☐ M 2 🗓 F Yrs Director 88 8-4-1921 NORTH CAROLINA 219-10-4719 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal Frust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TYYes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2539 FRANCIS ST Funeral 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2√2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) CLERK SOCIAL SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ AUGUSTUS JACKSON JANIE PEEBLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any Injury or other traum once. CHARLOTTE/W. JONES (DAUGHTER) 5702 RUBIN AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 🗆 3 Removal from State rematio 4 Donation □Other (Specify) ARBUTUS MEMORIAL PARK 3-27-2010 BALTIMORE, MARYLAND License JONATHAN HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of F 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Ent /r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Parse (Final disease or 10 dition resulting in eath) **Physician** Kespizatory darlure Dhe Honth /Medical Due to (or as a consequence of):

Chronic Interstitial Pulmonary Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as signed by the attending of IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Vonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours are: ....
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Nerra March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Ave Baltimore St. Agnes Hospital SANGITA VERMA 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

WAR 29 2010

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yates Physician/ March 04:10 M elones ZOIO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bay view Hospital Baltimore City Hopkins If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 M 2 XF Director 270-32-6218 2-24-1933 Usual Residence of Decedent 28a-f show tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director BALTIMORE TURNER STATION 1X Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? Funeral USA 651 S. AVONDALE RD. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No be filed within 72 hours after 1 ☐ Yes 2 ▼ No Specify: If Yes, Give 3 Widowed 4 XDivorced Completed Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SEWING MACHINE OPERATOR CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. မ **DEWITT OLVERSON** KATHLEEN MCELROY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4007 PAIGE VIEW RD. RANDALLSTOWN, MD ADRIAN YATES/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS MEM. PARK 4-1-2010 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MORTON & SONS F.H., INC. JAMES A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTIMORE, MD 1701-31 LAURENS ST. 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death). Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 N Probably 4 □ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) (are 6xter 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) March 26, 2010 Melinda Morton 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Barview Hospital Registrar

DHMH 17 Rev 7/2009

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** March 2010 4:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Ceriatric/Rehab Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. Ia Middle River Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** 1 □ M 2 🔽 F Director 214-20-8937 Maryland July 16, 1924 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States
14. Race - American Indian 21222 3416 Loganview Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Cafeteria Manager 12 years 17. Father's Name (First, Middle, Last) Schools 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H 7 is marked ot Joseph Zengel Olive Canoles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health and
Important: If Item 27 is n
any injury or other traun Jo Anne Baumgardner (Daughter) 6218 Commons Road Rosedale, Maryland 21237 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Gdns of Faith Cemetery 3/19/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Avenue Dundalk, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. led by the a detached for 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 11 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 descriting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD ASTERN BLVD, MD-21221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA STERM - 70 9. E 32: Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** APPEL HAROLD 2010 12:17 AM 13 Mar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Batimore City** Baltimore Sinai Hospital if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F Jul 4, 1945 MD Director 213-44-1962 64 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. inside City Limits 10b. County MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 415 Homer Street 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appel's Bar & Grill owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgie (McFarland) Appel Leo Appel ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 415 Homer Street Donna Appel Cumberland MD 21502 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 3/16/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** complications from Intracranial 32 days hemorrhas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PROVED BY MEDICAL EXAMINER Due to (or as a consequence of): CERTIFICATION the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 X No 1☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | TER Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred www.le 28c. Injury at Work? Socializing with customers of this Bar Richard Number or Rural Route Number, City or Town, State)

305 BEALL ST., CUMBER LAND

MD - 21502 5 Pending 1 Natural ours after death.
neral Director: A
filled in by the ft. investigation 9:00 PM 1XYes 2 □ No 2010 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō At Bar-Restaurant owned by him within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Begun. MD 13/2010 D0053928 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BEGUM, MD 2434 WI BELVEDERE AVENUE, BALTIMORE MD - 21215

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

knows

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 217-28-2993 78 22, Director 1931 July | Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examinar must be notified at Director 1 X Yes 2 □ No Maryland Dorchester Hurlock the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 411 Charles Street 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ 3 Widowed 4 Divorced White "natural" Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H Im 27 Is marked oth Be Charles Edward Christopher, Sr. မ Martha Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Healt. Important: If Item 27 any Injury or other t once. Wesley K. Andrews, Sr./Husband 411 Charles Street, Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) McKendree Cemetery 3/16/2010 Hurlock, Maryland 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, 21. Signatur, of Funeral Service Lix need MD 21631 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Joshve 07 Sequentially list conditions, Examine ran, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical ası IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) o Tyes 2 No detached 9 Unknown 9 Unknown is been signed by the should be detached of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an N page certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient this Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 65528 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Labib ND 300 Bym Street (I D 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

r	•		For State of Ma	ryland / Depa			Mental Hy	giene	10 00510
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Death	2. Date of Dea	Reg. No.	3 Time of Death
	Physicia		Joan Aiken				3/10/20		Year 3. Time of Death 3:28 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County o	
_	<i>,</i> 		105 142nd St.		Ocean C		T	Worces	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 221 – 20 – 9666 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 1/2/25/		9. Birthplace (State or Foreign Country)  DE
	3		Usual Residence of Decedent				1 22/20/		
	nyland I-f sho ied at	Director		10c. City, Town or Loc					10d. Inside City Limits  1X☐ Yes 2 ☐ No
	he Ma or 28a e notif	Dire	MD Worcester  10e. Street and Number	Ocean City	10f. Zip Code			10g. Citizen of Wh	
	with t	Funeral	105 142nd St.		21842			USA	
	death item		11. Marital Status 12. Was Decedent Ev Armed Forces?	If	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
35	after al", or Exami	d by	1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced Year or Dates.	lo 1	☐ Yes 2X No	Specify:			white
9500-612	hours natur dical B	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	ation	ina	16b. Kind of Bus	iness Industry
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ק ס	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	Bookk	.eeper	18. Mother's Nam		Dupont  Maiden Surname)	
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Maryland	e 1 and 2 should be file of Health and Mental I If item 27 is marked o r other traumatic eve		19a. Informant's Name/Relationship (Type, Print)		g Address (Street a				te, Zip Code)
o`	and 2 lealth sm 27 ther tu		Edward Aiken (husband)  20a. Method of Disposition		42nd St.	Ocean Ci			7
nor	age 1 ant of 1 tr. If its		1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispose cemetery, cremetery, cremetery	natory or other plac		Date 16-10		Square PA
Baltimore,	permit. Page 1 a Department of F Important: If its any injury or ot		21. Signature of Funeral Service Licensee						
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χ 2 2	h certi tendin r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome o	Petal death 3 🗔		;y			of delivery
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DIVISION	l or At after o Direct	Cert	4 Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit	edical	29a. Certifier 1 Certifying Physician: To the best of n	ny knowledge, death c	occured at the time	, date and place, a	nd due to the car	use(s) and manner	as stated.
	the Hohin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of examiners of examiners on the basis of examiners on the basis of examiners of e	amination and/or invest est of my knowledge, d	leath occurred at the	e time, date and pla	ce, and due to the	e cause(s) and man	ner as stated.
	5 5 Wit		29b. Signature and title of centifier		29c. License	number アンム	9	29d. Date signed (	Month, Day, Year)
	<u>}</u>		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P	trint)	1:1	- 1	7,011	0 15-104
	ET 12		Nicholas Borodulia cus	) 1209 0	portel l	teghwey t	Euret	isterd,	De 19944
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DHMH 17 Rev 7/2009

Stuart Garrison Bre		i <b>se Type or</b> State c	· Print in E of Maryland							gible.	00		00510
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Medical Examine	bedd	rt Garri				41 07 7			March 6,	2010			0004 hrs
	4a. Facility Name (if n 403A W. Sout	· -	street and numbe	er)		4b. City, Town, Frederick		r Death			County of ederick	Death	
Funeral	5. Social Security Nun	mber 6. Sex	7. #	Age (In yrs, I	ast birthday)	If Under 1 Y	ear If Under	r 24Hrs.	8. Date of Bi		D/YYYY)		ace (State or
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2121 ald be fi Mental I marked event,		Gary Br			10h Maili	- Addesse (O)	_L		Jane L	<u> </u>			
Baltimore, MD 21 pernit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er	George Gar			er		ng Address (Str Fairmon						State, Zip <b>341</b> 2	_ ′
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Baltimore, sernit. Pages I a Department of He Important: If ite Injury or other to	4 Donation 5 21. Signature of Funer		e		-5	Name and Addre			<i>c.c.</i>		_		
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Physician // // // // // // // // // // // // //	23a. Part I. Enter the d	disease, or complic one cause on each		d the death.	Do not enter	the mode of dyin	ng, such as car	rdiac or re	spiratory arr	est, shock	, or heart	A	pproximate Interval letween Onset and
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burilledical Certification: To Be Completed by Physician/Medi	(Check only one) 2 1 Ce	ertifying Physician edical Examiner:0	n the basis of ex	amination ar									use(s)
To roin	29b. Signature and title		nd manner stated	1.		29c. Licer	nse number			29d. Da	te signed	(Month, E	Day, Year)
	(a:	of A	all,	211		0.0	C.M.E.			March	6, 201	0	
	30 Name and address	•			,					L			
3	Carol Allan, M		Medical Exa			Street, Baltir	nore, MD 2	21201					
State Registrar	EYI .	Day Year) 2 20		ar's Signatu	A. A	arked							
		00	ue.		ORIGINA				-			<del>.</del>	

		1	For State Registrar	State of Mary		epartment of F Certificate of		Mental Hy	giene Reg. No	2010	09520
Phys	icia	_	1. Decedent's Name (First, Middle, Las					2. Date of De Month	ath Da	ay Year	3. Time of Death
	dica	al .	June Lee Baxte					3	1		7:30 A <sup>M</sup>
Exar	nine	er	4a. Facility Name (If not institution, given 2510 Coach House)			Frederi	r Location of Deat	'n		County of Death	
Funer	al le		5. Social Security Number 6. S		In yrs. last birti	hday) If Under 1 Year	If Under 24 Hrs	8. Date of Bir	rth	9 Rirth	place (State or Foreign
Direct			232–62–7608	□ M 2 💢 F   7	1	rs. Months Days	Hours Min.	(Month, Di	7/19	38 West	Virginia
and w		-	Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town	or Location		_		1.	10d. Inside City Limits
/aryla f sho	ŝ	5	-0		oc. Oity, Town	_	1				1 1 Yes 2 □ No
the 1	8	~ F	MD Frederic  10e. Street and Number	\$		Frederi 10f. Zip Code	.CK		10g. Ci	itizen of What Cou	ntry?
h with 23a o		교 교	2510 Coach House	Way		21701				USA	
r deat		Funeral	11. Marital Status	12 Was Decedent Eve	er in U.S.	13. Was Decedent of H		Specify Yes or No to Rican, etc.)	p-	14. Race - Ameri Black, White,	can Indian,
Tey, Ividal yidalid AIA 13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. sitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Exprime in out by nutilid at		yd F	1 Never Married 2 Married	Armed Forces? 1 ∐Yes 2X No If Yes, Give		1 □ Yes 2√□ No	Specify:	,		0	
hours tural			3 N Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	16a	Decedent's Usual Occur	ation		16b. k	Whi	
on 72 In 42 In 45 In 45		Completed	(Specify only highest gra	de completed)  College (1-4or 5+)		(Give kind of work done life. DO NOT use retired	during most of wo	rking		and or businesson	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Maryiano ZIZI 12 should be filed within h and Mental Hygiene. 7 is marked other than "		ခြ မ	12	College (1-401 3+)	Ho	ousewife			Но	memaker	
De file tal Hy d oth		å	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maider	n Surname)	
y a		၉	John Glenn Gardn				•	la Jenki			
MCH d2sh thang 7 is n traun			19a. Informant's Name/Relationship (	_		Mailing Address (Street					
1 and Heal Heal tem 2		-	Sherrie Baxter, 1 20a. Method of Disposition			8 Rocky Fou Disposition (Name of y, crematory or other place		Date		ocation - City or Te	
parimit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra			1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemovai from State		y, crematory or other plac own Crematory		/2010	Hann	rstown MD	
mit. F Sartm Sortar			21. Signature of Funeral Service Licer			22. Name and Addre		72010	inge	13CWI PD	
	ouce		Barbara.	A. Wille	mes)	John T Willi	ans Funera	l Home, 1	Bruns	wick MD 2	1716
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do n	ot enter the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
Physicia		1	Immediate Cause (Final disease or condition	Lua	56 C	ANCER					Onset and Death
/Medic Examin			resulting in death)	Due to (or as a c							0
		-0	Sequentially list conditions,	b. Due to (or as a c	onseguence o	if)·					
uted d ansit	<u> </u>	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 40 4 0	0.1004001100	.,,					
exection and and and and and and and and and an		Exa	that initiated events resulting in death) Last	Due to (or as a c	onsequence o	f):					
ficate be exphysician since build		edical	•	d							
ertifica ling pl			IF FEMALE:								
ath ce attendii for use		ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 Ectopic pregnand				23d. Date of deliver Month	very Day Year
the de		Physician/M	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	me or death	5 ☐ Other (specify) _					
that hed by detail			Part II. Other significant conditions	ontributing to death but r	not resulting in	the underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
law requires that been signed 2 should be controlled.	- [:	od by	4-117					1 1	Yes 2	Pro 3 □ Pro	bably 4 🗌 Unknown
aw re		plet						24a. Was		24b. Were aut	opsy findings available
The The ate has page		Completed						auto perf 1 □ Yes	ormed?	death?	ompletion of cause of 2 □ No
VICAL ician: T certificat ector, pa		Be	25. Was case referred to medical examiner?					ath (Check only	~ `		
Physi Physi this c		၉	1 Yes 2 ⊠No			tpatient 3 DOA Oth	4 LI Nursing I			6 □Other (Spec	ify)
Attending Phy r death.  ector: After this by the funeral c		ertification:	27. Manner of Death  1  Natural 5 □ Pending	28a. Date of Injury (Month, Day, Y	(e <i>ar</i> ) 28b. T	njury Wor	ryat k? Yes 2 □ No	28d. Describe	how inju	ary occurred	
Atten deatl ctor:		fical	2 Accident investigation 3 Suicide 6 Could not b		- At home, far	m, street, factory, office	res Z LINO	28f. Location	(Street a	ınd Number or Rui	ral Route Number.
al or /		Certi	4 ☐ Homicide determined	building, etc. (	(Specify)	•		City or To	wn, Stat	te)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of r miner: On the basis of ex and manner stated	xamination and	, death occurred at the tid/or investigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	e cause( , date ar	(s) and manner as nd place, and due	stated. to the cause(s)
To th within To th		Me	29b. Signature and title of certifier	$\Omega$		29c. Licens				ate signed (Month	, Day, Year)
			Custin	Jearre		Do	78821		ت	3/11/10	
7			30. Name and address of person who	completed cause of deat	th (Item 23a) (	Type, Print)	Mara -	0.4-1-	105	4	01
	Stat		AUSTIN PEARI 31. Date filed (Month, Day, Year) MAR 1	32. Registrar's	Signature	ININ 51,	IXEDE	KICK /	10,	217	<i>U</i> /
Reg			MAR 1	2 2010 > 2010	man ,	3. Sarked					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 March 8 3:35 A M Eleanor Marie Bayer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2🗶 F Hours Director Illinois 354-16-6744 84 Aug Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f Maryland Montgomery 1 🗌 Yes 2 🙀 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3701 International Drive, #632 20906 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Bily Allene Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is Paul J. Bayer/son 15 Oldham Road Arlington, Massachusetts 02474 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury ( 4 Donation 5 Other (Specify) Final Journey Cremato<del>r</del>y 3/12/2010| Woodbine, Maryland 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, M RUhomas atinsu M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Lung Cancer with metastasis to femur, spine, should disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Aspiration Pneumonia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): anding physician are as the burial. Physician/Medical Box 68760 for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 XNo Pregnant at time of death Month Day Year signed by the a d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, Completed 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 💂 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? 2 No ☐ Yes 2 X N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 유 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 🗀 No Accident Investigation 6 Could not be within 24 hours after death

To the Funeral Director: / 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign re and title of certifie D66249 March 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Jonathan Duran 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (M 32 Registrar's Signature State T6 2010 Breun Registrar

Pamela Jewel Buckley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certin	ficate of <i>E</i>	eath			Reg. No.	
Physici		1. Decedent's Name (First, Middle, L	.ast)					Date of De    Month	eath Day Yea	3. Time of Death
/ledical Exami	ner	Pamela 3	Jewel Buck	Ley				March 1		1545 hrs
		4a. Facility Name (if not institution,		_	1	City, Town, or L	ocation of Dea	ath	4c. County	of Death
		5810 Reisterstown Road				Baltimore				
Funeral		Social Security Number     6.	Sex 7. Age	(In yrs. last	birthday)	Months Days	If Under 24I Hours M	Irs. 8. Date of 8	Birth(MM/DD/YYYY	9. Birthplace (State or Foreign
Director		214-04-3199	M 250€F	39	Yrs.	World is Days	riours IV	Aug 2	23, 1970	Country) MD
		Usual Residence of Decedent								
, any		10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
show	卢	MD Carro	011		Westmir	ster				1 X Yes 2 No
daryland 28a-f show	š	10e. Street and Number	1		1	0f. Zip Code	-		10g. Citizen of Wi	nat Country?
ith the Maryland 23a or 28a-f sho notified at once.	Director	537 Gentry C	<b>-</b>			211	57		USA	
with 18 23;	<u>ra</u>	11. Marital Status	12. Was Decedent	Ever in U.S.		ecedent of Hispa	anic Origin? (	Specify Yes or N		e - American Indian, Black,
eath item	Funeral	1 Never Married 2 Marri		₹ No	If Yes,	specify Cuban, I	Mexican, Pue	rto Rican, etc.)	White	e, etc.
fter d I", or		3 Widowed 4 Divorce	ed If Yes, Give Year	Ž 140	1 Y	s 2 X No	specify:		Specify:	White
ours a	d by	15. Decedent's Education (Specify	only highest grade com	pleted) 16		Usual Occupatio			16b. Kind of Bu	usiness/Industry
72 hc	ete	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during most	of working life, D	OO NOT use r	etired)	1	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once	ompleted	12			Wait	ress			Resta	aurant
21215-00 uld be filed wit Mental Hygien marked other c event, the M	ဒ္ဓ	17. Father's Name (First, Middle, La	st)			18	Mother's Na	me (First, Middle	Maiden Surname	) norman
2121 wld be fil Mental I marked c event,	Be	John Buckley	, Sr.			-	Mollie	Zimmeri	nan	етшан
AD 21 2 should h and Me 27 is ma matic ev	ျ	19a. Informant's Name/Relationship	(Type, Print)	I	19b. Mailing A	dress (Street	and Number o	or Rural Route No	umber, City or Tow	n, State, Zip Code)
y, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiene. Item 27 is marked other than "natural", traumatic event, the Medical Examine.		Jackie Buckley	Mother			ntry Ct			r, MD 21	
ore, MD See I and 2 shout of Health and 1: If item 27 is 10 ther traumatic		20a. Method of Disposition  1 X Burial 2 Cremation	2 Pamoust from Sta		ce of Dispositio matory or other	n (Name of ceme place)	etery,	Date	20c. Location -	- City or Town, State
imore Pages   ment of P tant: If i		4 Donation 5 Other Spec		···		erd Cem.	_ 3/	23/2010	Ellico	ott City, MD
Baltimore, permit. Pages I at Department of Hee Important: If ite		21 Signature of Funeral Service Lin		10000	22. Nam	e and Address o	of Facility Pr	itts Fin	neral Hon	ne & Chapel, PA
<b>9</b> 7 7 1		John K A	at -						inster, N	
Physician		23a. Part . Enter the disease, or co failure. List only one cause on		he death. Do						
Medical	2.4	Immediate Cause (Final disease	a. Heroin a	nd co	caine i	ntoxicat	ion			Death
Examiner		or condition resulting in death)	Due to (or as a conse	quence of):						
		Sequentially list conditions,	b							
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):						
	- CS I	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	-					
760, icate be executed physician and the burial - transit	Ä		d							
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed anth. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	/Medical	X UNPENDED	X AMENDED $23a$	sp 18.	per F.	3/23/	(20100	arroll	Co., wjl	
760, Ecate be g physici the buri	ĕ	IF FEMALE:	23c. If yes, outcom	e of pregnar	ncy				23d. Date of	delivery
587 artific ling p		23b. Was decedent pregnant in the past 12 months?	1 Live birth			death 3	Ectopic preg	inancy	Month	Day Year
Box 687 e death certific the attending	Si	1 Yes 2 No 9 V Unkno	wn La Pregnant at t	ime of death	5 Other	(Specify)			4	
be de y the red fi	Physician	Part II. Other significant condition	3 OTKHOWIT	hud not room	ding in the cod	rivino novoc niv	on in Dort I	23o Did	tobacca use contri	ibute to the cause of death?
of Vital Records, P.O. or Physician: The law requires that the Nether this certificate has been signed by neral director, page 2 should be detach	ğ	rait ii. Other significant condition	s continuating to death	but not resu	nting in the bild	arryling cadae giv	en in raiti.			Probably 4 V Unknown
S, F puires an sig				_				- 24a. Wa		
ords, w requir as been s	Completed							auto	opsy p	Were autopsy findings available prior to completion of cause of
Rec The la icate h	E									death?  ✓ Yes 2 No
tal Rectian: The	ادہ	25. Was case referred to medical				26.Place o	f Death (Chec	k only one)		
Vit.	Ö	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 EF	R/Outpatient 3	DOA O	ther 4 Nur	sing Home 5	Residence 6	Other: Scene
O Of Value Ph. L. After the funeral		27. Manner of Death	28a. Date of Injur (Month, Day,Ye		Bb. Time of Inju	y 28c. Injury	at Work?		how injury occum	ed
ion tendi or: /	읥	Natural 5 Pending Accident Investig	F4 2/17/		d 3:40	pm 1 Ye	s 2 <b>X</b> No	unk		
Division tal or A tendi is fice death.	iji	3 Suicide 6 Could n	28e. Place of Inji				lding, etc.	28f. Location	(Street and Number State) 5810	er or Rural Route Number, City
DIVI spital or nours after neral oir filled in	Certification:	4 Homicide determi		una 11	n motel	гоош		Rm~315	Baltimo	Reisterstown Rd re, MD (Red Carpe
24 hos Fun etely		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge,	death occurred	at the time, date	and place, a	nd due to the cau	use(s) and manner	as stated.
Division  To the Hospital or Artendi within 24 hours after cleaft. To the Funeral Uncedor: ,	Medical		ner:On the basis of exam and manner stated.	ination and/	or investigation			d at the time, dat		
.//.	ž	29b. Signature and title of certifier	*	0		29c. License				ed (Month, Day, Year)
WIL JUN		Kot. Un	10m. //	- Tak	let on	O.C.M	.E.		March 18, 2	2010
0	1	30. Name and address of person wh		eath (Item 23		1				
		Patricia Aronica-Pollak N	MD. Assistant M	edical Ex	aminer 1	11 Penn Stre	et, Baltim	ore, MD 212	01	
		31. Date filed (Month, Day Year)	32 Registrar		1					
Regis	rar	MAR 232	010 Cleneus	<i>⊅ ⊈</i> .	Dark					

Registrar DHMH 17 Rev 1/2001

State

ERNEED Mendo

MAR 15 2010

31. Date filed (Month, Day, Year)

826 washington

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09524 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2010 Year 9 Hannah Spedden Bennett 8:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6 Sex 7. Age (In yrs, last birthday) Days 1 □ M 2 1 → F Months 220-16-7532 84 Director Maryland Feb. 14, 1926 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester East New Market 1 ∏Yes 21X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5525 Oyster Shell Point Road 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify white 2 Specify: 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) kitchen manager restaurant 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bain Beckwith Florence Spedden ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Omro Willey son 5525 Oyster Shell Pt Rd., East New Market, MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dorchester Mem. Park 3/12/10 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** b(ovasc disease or condition resulting in death) Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in a deal of the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of or Attending Physician: The law requires that the death certificate be executed physiclan and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical by the ettending place as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ☑ ☑ has le 24a. Was an After this certificate had funeral director, page 2 X No 1 □Yes Be 26. Place of Death (Check only one) Other: 4 Ursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L filled Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar

State

29b. Signature and title of certifier

dress of person

Date filed (Month, Day, Year) MAR 12 2010

Na

and a

ad cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

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29d. Date signed (Month/Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O3 Wallace Bloodsworth 09:23 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3/1/1/hyw VICOMICO . Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min Dec. 26, Year) 925 Mary land **Director** 218-20-4248 84 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2X No MD Dorchester Wingate 10f. Zip Code 10g. Citizen of What Country? Funeral 2145 Farm Creek Road 21675 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. ğ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) . Page 1 and 2 should be filed within trent of Health and Mental Hygiene. tant: If item 27 is marked other than jury or other traumatic event, the N College (1-4 or 5+) boat builder marine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Noble Bloodsworth Minnie McGlaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger W. Bloodsworth Jr. son 1609 Stone Boundary Rd., Cambridge, MD permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Parks Family Cemetery 3/11/10 4 ☐ Donation 5 ☐ Other (Specify) Wingate, MD Signature of Funeral Service 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ ITFART FAILURE CONSPSTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examine 010 MY0 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury SUVD Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. signed by to the second of the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 DrNo မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier ပ 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 100 E Carroll St. Salisbury MD 21801 M.D. Registrar's Sign

DHMH 17 Rev 7/2009

State Registrar

# permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoies. Baltimore, Maryland 21215-0036 Physician/ Examiner

Medical

Examine

Physician/Medical

Completed by

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Certificate: To

Medical

	Please 1		nt in Black aryland / De					Are Legible	
For State Registrar		Otato or ivit	-	ertificate		III IVIE	, 0	g. No. 🗘 🕦 📗 🕜	00526
1. Decedent's Name	e (First, Middle, Last)					2	2. Date of Death Month	Day Year	3. Time of Death
	Winifred					Ma	arch 10	Day 2010 Year	11:00 a⁴
-	not institution, give st				vn, or Location of			4c. County of Dear	
Hartley 1  5. Social Security Nu	Hall Nursi		(In yrs. last birthda		noke Cit	_	3. Date of Birth	Worceste	
414-32-54 Usual Residence of	483	М 2хД F	99 Yrs	Months D	Pays Hours	Min.	(Month, Day Y	1910 Ind	thplace (State or Foreign untry) 1ana
10a. State	10b. County		10c. City, Town or	Location					10d. Inside City Limits
MD	Worcester		Pocomok	e City					1 🔀 Yes 2 □ No
10e. Street and Num	nber			10f. Zip Co	ode		10	g. Citizen of What Co	ountry?
1006 Mark	et Street			2185	51			USA	
11. Marital Status		<ol><li>Was Decedent E Armed Forces?</li></ol>		<ol><li>Was Decedent If Yes, specify</li></ol>	of Hispanic Origi Cuban, Mexican,	n? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, Whit	
1 ☐ Never Marri	ied 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No	1 🗆 Yes 2 🕽	No Specify:			Specify:	white
	15. Decedent's Edu	Year or Dates.	16a. De	cedent's Usual O	ccupation		1	6b. Kind of Business	
(Spec	cify only highest grad		(G		one during most of	of working	['	ob. Milu of Business	пицану
12	oriday (U-12)	Juliege (1-4 UF 5		kkeeper			IV.	anufactur	ing
17. Father's Name (F	First, Middle, Last)				18. Mother	's Name (F	First, Middle, Ma	iden Surname)	
Fredrick A	Alfred Par	khurst			Mar	tha I	ove Kin	ıg	
19a. Informant's Na	ame/Relationship (Type	e, Print)						ity or Town, State, Zi	
Dan Blai:			181	4 Cedar	Hall Ro	ad, F	ocomoke	City, MD	21851
20a. Method of Disp	oosition Cremation 3 D R	temoval from State		sposition (Name or crematory or other		Dat	e 20	Dc. Location - City or	Town, State
	5 Other (Specify)		Greenwood	Cerretery	3,	/15/2	010 K	noxville,	TN
21. Signature of Fur	neral Service Licenses	Dead	,	Holloway 107 Vine	funera St., Po	1 Hom	ne, Profe oke City	essional Ass , MD 2185	cciation 1
23a. Part 1. Enter the shock, or hear immediate Cause (I disease or condition resulting in death)		cations that caused cause creach line  Due to (or as a	mary		dying, such as ca		, ,	,	Approximate Interval Between Onset and Death
Sequentially list conif any, leading to im	mediate	Due to (or as a	consequence of):						
cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	iinjury s c	Due to (or as a	consequence of):						
	<u> </u>								
IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	Sc. If yes, outcome of 1 Live Birth: 4 Pregnant at g Unknown	2 Fetal death	3				23d. Date of de Month	livery Day Year
Part II. Other signifi	icant conditions con	tributing to death bu	ut not resulting in th	e underlying cau	se given in Part I.		23e. Did toba		the cause of death?
							24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
25. Was case referre	ed to medical			- 0	6. Place of Death	Checko	1	No 1 ∐ Yes	s 2 No
examiner? 1 Yes 2	No Ho	ospital:	nt 2 🗆 ER/Outpa		Other:	`		ce 6 Other (Spec	if <sub>t</sub> ()
27. Manner of Death	5 Pending	28a. Date of injur (Month, Day,	y 28b. Time	e of 28c.	Injury at work?	280	d. Describe how		
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, farm, (Specify)		1 Yes 2 N		f. Location (Stre City or Town, S	et and Number or Ru State)	ral Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 cate has been signed by the attendin page 2 should be detached for use within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director,

2 Accidate A 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 3 -/0 - £0/6 29b. Signat

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

AR AN R ARACH MUC

DN 4 31. Date filed (Month, Day, Year) State

Director

Funeral

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Completed

To Be

Physician/

Medical

**Examiner** 

**Funeral Director** 

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a, 25 & 26 per phys. G901 3/29/10 dk

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** BRENT R. BAILEY 4:05 A 21 20K /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **CRAPO** DORCHESTER 2126 ANDREWS RD Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**⊠** M 2□ F Yrs 11/5/1942 MARYLAND 67 Director 214-38-7945 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov 1 ☐ Yes 2X No Director MARYLAND DORCHESTER **CRAPO** 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int; If item 27 is marked other than "natural", or items 23a or: 21626 USA 2126 ANDREWS RD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces' 1 X Yes 2 If Yes, Give 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify. Completed by 3 Widowed 4 Divorced WHITE Year or Dates 1965 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Mudical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURING MACHINIST 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIE MICHOVICH GEORGE CLEVELAND BAILEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2126 ANDREWS RD., CRAPO, MD 21626 PATRICIA L. BAILEY / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/22/2010 CAMBRIDGE, MD MID SHORE CREMATION CENTER 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licenses CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 - Z 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cudeac amsi MINS **Physician** resulting in death) /Medical Due to (or as a consequence of): artery Lucaus Examine YR5 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ASCUD and Due to (or as a consequence of): burial-1 the attending physician ned for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No o. detached 9 Unknown þ ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No has 2 No certificate 1 TYes 1 ☐ Yes Division of Vital Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Wires 10 D0010688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 Eastern Shue Duive Salishey, but 21801 31. Date filed (Month, 32. Rei State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / 09528 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month 1:40 P M Yvonne Conley March 13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 10713 Hunting Lane Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Month, Day, Yea Jan 26, 1 1 □ M 2 🛛 F Days Hours Min. Months Director Yrs 63 214-46-7056 1947 Washington. Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10713 Hunting Lane 21044 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceder Lvc. Armed Forces? 1 Yes 2 XNo Black, White, etc. Š 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

27 is marked ot

traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental be Important: If item 27 is marked o any injury or other traumatic eve once. ပ Leonard Mason Irick Mildred Irene Sword 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Bryan Conley/son 10199 Maddox Ridge Road Turner's Station, KY 40075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 3/16/2010 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, M Sign Rure of Funeral Service uante ( M00957 MD\_21029 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final olon Physician/ ancer months disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☑ No 2 1 No Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, i To Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. n D erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of lρ MD 5450 Drive Knoll Columbia North 31. Date filed (Month)

State

Registrar

32 Registrar's Signature

ration

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DIVER BLISS Physician/ March 200 1020 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death INSPITA WAS HANDIERE MAUNSRUN If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 215-26-2180 PA Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD Washington 1 Yes 2 X No Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 504 North Pennsylvania Avenue 21750 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. þ 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 8 Assembler Parts Remanufacture marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ injury or other traumatic Joseph Divelbliss Carrie Alice Diehl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olive M. Divelbliss/Wife 504 N.PA Avenue Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/18/2010 Needmore, PA Tonoloway Baptist 21. Signature of Funeral Service License 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Gequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2 s e Hospital or Attending Physician; The I 124 hours after death. e Funeral Director; After this certificate h 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 3 | 07/20(0 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident iniury 5 Pending 10:30 1 Yes 2 💢 No Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 504 Pennsyl Vania Ave Hancock, Mo 2, 150 determined HOME Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and ti ٥ 29c. License number 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Konbert Men no PANKWAZ Malieso 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAR 29

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:50A M Louise В. Duva11 12, March 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 □ M 2 🔀 F Months Days Hours Min. 89 214-16-0086 March 23, Director 1920 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 🔀 No Funeral Director Montgomery Maryland | Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or item 27 ls marked other than "natural", or items 23a or item 27 ls marked other than "natural", or items 23a or items any Injury or other traumatic event, the Marical Examinar mant be a ginee. 25511 Oak Drive 20872 U.S.A. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Completed by Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Herbert Barnes Rosa May Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 19a. Informant's Name/Relationship (Type. Print) 12016 Bethesda Church Road, Damascus, Maryland <u> Jerry B. Duvall - Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/19/2010 4 ☐ Donation \_ 5 ☐ Other (Specify) Damascus Cemetery Damascus, Maryland 21. Signatur → of Funer → I Service License Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Tovert 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** DemenI year. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year P.0. ed by the detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 : autopsy certificate 1 ☐ Yes 2 😿 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation a er death. I **Director**; Af d n by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signature/ 29c. License number D38262 March 12, 2010 a dress of person who complete use of death (Item 23a) (Type, Print) Anurita Mendhiratta, 2401 Research Boulevard, Rockville, Maryland 20850 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 0052 Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death <sup>Day</sup> 2010 Physician/ March 12 12:23 p M Robert Lee Dennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Worcester Pocomoke City 1210 Market Street, Apt. F-4 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In vrs. last birthday) oct. 20 1 X M 2 🗆 F Hours 1941 Maryland Director 68 216-38-8686 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Pocomoke City 1 Yes 2 □ No Worcester 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21851 USA 1210 Market Street, Apt. F-4 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: 3 Widowed 4X Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Chemical 12 Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian Alda Workman Ira Washington Dennis permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Johnson Road, Pocomoke City, MD 21851 Peggy Johnson (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/15/2010 Salisbury, Maryland Salisbury Crematory 22. Name and Address of Facility
Holloway Funeral Home, Professional Association
107 Vine Street, Pocomoke City, MD 21851 21. Signature of Mneral Service Licenses Milla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final accid ENT Physician/ disease or condition resulting in death) Medical Examiner ENSI a mentiody list occupitions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No To the Hospital Sector death.

Within 24 hours effer death.

To the Funeral Lirector Aff Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

29b. Signature and title of

31. Date filed (Mon ) and

and address of person who completed cause of death (Item 23a) (Type, Print)

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Pocomohe City, MD 21851

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09532 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year 01:15 M からゆく 11 2010 1 S /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** land If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 22, 1949 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F Maryland Director 219-54-1705 60 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 XYes 2 No Deer Park Garrett MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, Item Medical Eventher must be now Injury or other traumatic event, Item Medical Eventher must be now Injury or other traumatic event, Item Medical Eventher must be now Injury or other traumatic event, Item Medical Eventher must be now Injury or other traumatic eventher. USA 21550 120 Church Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Coal Company Coal Miner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Elizabeth Jane Stump Victor Maurice Ervin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Church St., Deer Park, MD 21550 June Ervin/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 3/18/10 4 Donation 5 □ Other (Specify) PaughErvin Cem. Deer Park, MD 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee Second St., Oakland, MD 21550 Matte 203 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each whe Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** armonary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 24 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director After this certificate has been signed by the attending physician and filled in by the furned director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural 2 ☑ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who cor

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Cleo Eichelberger March 23, 1:05 A. 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 € M 2 □ F 91 160-16-9503 **Director** Oct.12,1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show 10b. County "natural", or Items 23a or 28a-f shov dical Examiner must be notifled at 1 ☐ Yes 2 No Md. Washington Smi thsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22703 Cavetown Church Rd. 21783 U.S.A Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1. Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: by 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plaster Homes permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If tem 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Eichelberger Eillie Sweeney ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22703 Cavetown Church Rd. Smithsburg, Md. 21783 Alice Hawes (Companion) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 24, Smithsburg, Md. Smithsburg Crematory 4 Donation 5 Dother (Specify) 2010 21. Sign tue of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Home 1601 Pennsylvania Ave. Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** prone 4-each /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a by leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by g, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er deal To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Regi<u>strar</u> 31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

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32. Registar's Signature

30. Name and address of purson who impleted cause of death (Item 23a) (Type, Print)

D28365

-23-10

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:30 A M Cody Wade Ferguson 2010 <u>March 13</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 126 Cholma Lane 0akland Garrett If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 20 09/10/1989 Director 217-25-2917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD 0akland Garrett 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 126 Cholma Lane United States 21550 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susan Mason Gary A. Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Cholma Lane, Oakland, MD 21550 Susan Newton, Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oakland, MD 03/16/2010 Oakland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 21. Signature of Funeral Service Licensee 21 N. Second Street, Oakland, MD 21550 Kathe Scory 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ី Residence 6 ☐ Other (Specify)

**Physician** /Medical Examiner

The law requires that the death certificate be executed

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certificate

Box 68760,

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of Vital Records,

Division

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Saltimore, Maryland 21215-0036

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and Mental Hygiene.

.. Pages 1 and 2 should by timent of Health and Ment; tant: If Item 27 Is marked jury or other traumatic e

physician and the burial-transil use as atter for u signed by the a should I page 2 s : After this certifical funeral director, p Certification: To al or Attending F safter death. I Director: After d in by the funera

1☐Yes 2☐No 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 5 Pending investigation

6 Could not be determined

3 ☐ Suicide

4 Homicide

Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day

death (Item 23a) (Type, Print)

Registrar's Signature

State Registrar

completely filled in by

cal

within 24 hours a Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 1622PM DARWIN GLISAN 2010 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Memorial Hospital Cax Count Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F **Director** 164-28-8239 02/27/1936 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No MD Friendsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 Second Avenue 21531 United States Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 MaYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Chemical Co. 12 should be filed with and Mental Hygien 7 Is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Glisan Isa ٥ Rosenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is n any injury or other traun once. Eleanor Glisan, Wife 910 Second Avenue, Friendsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2010 Silbaugh Crematory Uniontown, PA 22. Name and Address of Facility
David A. Burdock Funeral Home,
21 N. Second St., Oakland, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eriosc disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Tes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate half 1 ☐Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 🗆 No 1 Inpatient Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

				04-40 05 84-	under al / Dane	artmant of Haalth	and Mental Hy	raiene		
			For State	State of Ma		artment of Health		Reg. No. 7	nin	00536
_			Registrar	41		lineate of Death	2. Date of D		UIU	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Las Marian Elizab		V		Month	18 <sup>Day</sup> 20	10 Year	2:55 P M
	/Medic		4a. Facility Name (If not institution, give		1	4b. City, Town, or Location			ounty of Death	2.00
	Examin	er	Egle Nursing Home			Lonaconin		Al	legany	
with.			5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year   If Und	or 24 Hrs   9 Date of B	irth		ace (State or Foreign
	Funeral Director				8 Yrs.	Months Days Hours	June	bay, Year) 5 1931		
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	how	_	10a. State 10b. County		10c. City, Town or Lo					to the state of t
	e Ma	cto	MD Allegan	Y	Westerr			l	411111111111111111111111111111111111111	
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	hours after death with the Maryland tural", or items 23a or 28a-f show at Exp citien must be rediffed at	ā	235 Green St				0.1-1-0.70		4. Race - America	
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hispanic If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	10-	Black, White, e	rtc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 🔯 N If Yes, Give Year or Dates:	0	1 □Yes 2XINo <i>Sp</i> ec	ify:	5	Specify: whi	te
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene.  is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show armatic event, it is "selfed Eximiliar mast be refilled at	IJ	19a. Informant's Name/Relationship (7	Type. Print)		ing Address (Street and Nur				
	1 and 2 Health a em 27 is		Mark Harvey/ son			Kelly Ave, W				562
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Romovol from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	03/19/2010		ation - City or To	Maryland
Ĕ	it. Pages rtment of I rtant: If ite njury or o		4 Donation 5 Other (Specify		Cumberlar	nd Crematory				
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licen	see	17	2. Name and Address of Fa	·			21562
_	80 <b>5 8 8</b>		1 than	( 13 m		11 Church St			arytand	21562 Approximate
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	one cause on each iir	ie.			/ arrest,		Interval Between Onset and Death
Carlot Wall	Physician		Immediate Cause (Final disease or condition	a Hepa	scellula	Caro	inons			months
	/Medical Examiner		resulting in death)	Due to or as	a consequence of):					
	Examine	_	Sequentially list conditions,	b	a consequence of):					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence or.					
	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
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687	phys phys the			d						
×	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				2	23d. Date of deliv	ery
Вох	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		☐ Ectopic pregnancy ☐ Other (specify)		- 1	Month	Day Year
o.	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown						
٠ <u>.</u>	that ned t	Y P	Part II. Other significant conditions of				art I. 23e. D	id tobacco u	se contribute to t	he cause of death?
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0	규 도목	4								
ပ္သ	w requires that s been signed t : should be deta	lete	unellefo	ريا			24a. W		24b. Were auto	opsy findings available
Rec	The law requ te has been age 2 should	omplete	unllete	<b>U</b>			aı pı	utopsy erform <u>ed</u> ?	24b. Were auto prior to co death? 1 □ Yes	ompletion of cause of
tal Rec	The la ate has page 2	e Completed by	25. Was case referred to medical	رب		26. P	a	utopsy erformed? s 2 No	prior to co death?	ompletion of cause of
f Vital Records,	iclan: certifica ector, g	Be			ent 2 ☐ ER/Outpati	Othoria	an per 1 □ Ye lace of Death (Check on	ortopsy erformed? s 2 No ly one)	prior to co death?	mpletion of cause of 2 □ No
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of	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1	Hospital: 1 Inpati  28a. Date of Inju (Month, Dane)  28e. Place of Inju building, ei	ury - At home, farm, so (Specify)  of my knowledge, de of examination and/or	ent 3 □ DOA Other: 42  of 28c. Injury at Work?  M 1 □ Yes 3  eth occurred at the time, da	an a	topsy erformed? s 22 No ly one) esidence to be how injuring (Street and Town, State) the cause(sme, date and 29d. Date	prior to ct death? 1 □ Yes 6 □ Other (Spec.) y occurred  and Number or Rui ) and manner as	ify)  al Route Number, stated. to the cause(s)

State Registrar

31. Date filed (Month, Day, Year) **MAR 2 2 2010** 

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21.532

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who complet

31. Date filed (Month

1ane

ause of death (Item 23a) (Type, Print)

M.D.

D0068681

Forest Glen Rd., Silver Spring, MD. 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09538 Reg. No. 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mogth 3 0224 2010 Kenneth Wilson Jarrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hicomia AUSSUN 8. Date of Birth
Jan. 23, 1925 If Under 1 Year If Under 24 Ars. 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Months Mary Land 85 Yrs Director 218-16-5267 Jsual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2 X No Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21643 USA 6332 Cabin Creek Road 12. Was Decedent Ever in U.S.
Armed Forces? 1943
1 X Yes 2 No
If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 nours after 1 Yes 2 X No "natural", Specify: 3 X Widowed 4 ☐ Divorced White oe filed wn...
Mental Hygiene.
'ed other than "natu..
'nt, the Medical Ey Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company 11 Testman other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Bertha Lager Jackson William Edward Jarrell permit. Page 1 and 2 should be Department of Health and Menimportant: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O. Box 712, Hurlock, MD 21643 Jay Jarrell/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 3/12/2010 4 Donation 5 Other (Specify) Beulah, Maryland . Signature of Funeral Service Lic Name and Address of Facility Eller Funeral Home, P. O. Box 207 Of Main Street, East New Market, MD 21631 25a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Sepre Shock disease or condition Medical resulting in death) as a consequence of Examiner Congestive heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of Pheumonia sician and bunial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law has page 2 autopsy performed' this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 D No 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending
Investigation To the rusping after death.

Within 24 hours after death.

To the Funeral Director: Aft M Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D18525 03-08-10

State Registrar 30. Name and address of person

100 E. Carroll St. Salisbury MD

ed cause of death (Item 23a) (Type, Print)

P.R. M.C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Amend Items 25 State of Maryland of 1 - For Amend Items 25 State of Maryland of 3	P <mark>216</mark> Cer	72090ta tificate c	Health of Death	and Me	ental Hyg	giene Reg. No	010	09539
Physic		1. Decedent's Name (First, Middle, Last)	10	cuin			2. Date of Dea		(20/0)	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death / 4c. County of De						County of Deat	h
	M.	The Johns Hopkins Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last bi.	rthdau)	Baltimo		er 24 Hrs.	8. Date of Birt	h	9. Birt	hplace (State or Foreign
Funeral Director		491-48-1961   0. 36X   1 \( \triangle \) M 2 \( \triangle \) K   62	Yrs.		ays Hours	Min.	oct. IC	, Year 19	Co	rmany
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Maryla -f sho ed at	tor			er Spr <b>i</b>	ng					1 ☐ Yes 2X No
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036 urs after de al", or items xaminer m	by Funeral	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:		Was Decedent If Yes, specify ( 1 ☐ Yes 2 ☐			ican, etc.)		Black, White Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give life.	dent's Usual Or kind of work de DO NOT use re	one during m etired)		g		nd of Business	
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maryland and 2 should be file eath and Mental Hy m 27 is marked oth ner traumatic event				ng Address (St Mintwo						7ip Code) 0901
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe once.		1 Rurial 2 Cremation 3 Removal from State cemet	ery, crer	osition (Name of matory or other e1 Ceme	place)	03/ <del>0</del>	ቻ <del>1</del> /2010		cation - City or	
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TO THE REAL PROPERTY.		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ent	er the mode of	dying, such	as cardiac o	r respiratory a	rres ,	,	Approximate Interval Between Onset and Death
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ecords, P.O. F aw requires that the de s been signed by the a 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting	in the	underlying cau	se given in P	art I.	23e. Did t		,	o the cause of death?
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Vital   sician: Th certificate irector, pa	Be C	25. Was case referred to medical examiner?			26. Pla	ice of Death	Check onl o			
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On On Ollon Ph. After th	tion:	1 Natural 5 Pending (Month, Day Year)	. Time o		Injury at Work? 1   Yes 2		8d. Describe I	now injury	y occurred	
Division of Vital Re To the Hospital or Attending Physician: The is Within 24 hours after death. To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, 1 building, etc. (Specity)	arm, str	eet, factory, off	fice	2	8f. Location ( City or Tow		d Number or F	iural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical C	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	je, deat nd/or ir	h occurred at to	he time, date my opinion,	and place, a death occurr	and due to the ed at the time,	cause(s) date and	and manner a d place, and du	s stated. ue to the cause(s)
To the within 2 To the comple	Me	29b. Signature aper jitle of certifier	_	29c. Lie	cense numbe			29d. Date	e signed (Mon	th, Day, Year)
		1 . M.D.		1/	155-	000		11/14	Hich L	,0010
		38 Name and address of person who completed cause of death (Item 23a	) (Type	Print)				lfe S	t, Baltim	ore, MD, 21287
St Regist	ate rar	31. Date filed (Month, Day, Year)  NAR 0 5 2010  Registrar's Signature	ba	Ked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		·	1 - For Amend Items Registrar	251,291,28	ery fan	Pere Cer	r <b>t901</b> t,0 tificate c	3  26  12 f Death	endan		iene eg. No.?	10	19561
	Dhysisi		1. Decedent's Name (First, Middle, Last)							2. Date of Deat		Vear	3. Time of Death
	Physici /Medic		Doris Elizabe	th Moor	re					Februar	y 20 2	010	11:35 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st				4b. City, Town		of Death		4c. County of Death		
- Sept			William Hill Man  5. Social Security Number 6. Sex		n /In 150 I	lo at hirthday)	Fas		r 24 Hrs	P. Date of Birth		lbot	place (State or Foreign
	Funeral Director			M 2⊠ F 7. Ag	e (in yrs. i 90	ast birthday) Yrs.	Months Day		Min.	8. Date of Birth (Month, Day Feb. 12	Year) 1920	Coul	rvland
			Usual Residence of Decedent	1	50					120. 12	, 1520		c y renta
	rylan show	_	10a. State 10b. County		10c. City	y, Town or Loc	ation					1	0d. Inside City Limits
	e Ma 8a-f s	Director	MD Talbot				East						1⊠Yes 2□No 
	vith th	Dire	10e. Street and Number				10f. Zip Cod		4	1	0g. Citizen of V		ntry?
	sath v	eral	501 Dutchman's La		Cuanta III	C 140.11	Van Danadant	2160			USA		and testion
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, it is incided Exacilizate untal to incilling at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 □Yes 2★1 If Yes, Give Year or Dates:			Yes, specify C			ecify Yes or No- Rican, etc.)	Blad	ck, White, v: <b>wh</b>	
Ö	2 hou	Completed	15. Decedent's Educa	ition			ent's Usual Oc			. 1	16b. Kind of Bu	usiness/In	dustry
2	thin 7 ne. wan "r	nple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	5+)	`life. L	OO NOT use ret	ne during mos tired)	SI OI WOFKII	ng			
	ed wi lygier her th		11			1	nostess	T				stau	rant
and	be de la	Be	17. Father's Name (First, Middle, Last)  Frank Kramer							(First, Middle, I Smith	Maiden Surnan	1e)	
Maryland	should be filed within ind Mental Hygiene. i marked other than imatic event, in Ma	ဥ	19a. Informant's Name/Relationship (Typ	a Print\		10b Mailin	a Address (Str			al Route Number	City of Town	State 7	Cadal
≅	au s		Lee Moore	2. 1 HIN)	son					ville,			, code,
ē,	es 1 and 2 of Health I Item 27 i		20a. Method of Disposition				sition (Name of natory or other)				20c. Location -		own, State
Ë	Pages nent of int: If Its iry or o		1 ☐ Burial 2 ☐ Fremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			of Deli	:	2/23	/10	Delmar	DE	
altimore,	permit. Pages Department of Important: If II any Injury or once.		21. Signature of Funeral Service Licensee	)						mas Fun			. A .
<u>m</u>	8 3 E 6	()	Ah wi lown			70	00 Locu	st St.	, Cam	bridge,	MD 21	613	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each li	d the death	n. Do not ente	er the mode of	dying, such as	s cardiac c	or respiratory arr	est,		Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition		Cas	dio	Pul	mone	my 1	arred			Priset and Death
	/Medical Examiner		resulting in death)	Due to (or	a consequ	uence of):	<u>- /</u>		)	01	5		10.: 4
		7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	W.	MARK	7 100	ans	WI	to hy	POXEN	42	100pms
	nsit	nin	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	rence or).	8			14	11		/
	execting and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequ	uence of):			0	M	PICAL EXA	MINER	
8760,	icate be executed physician and the burial-transit	dical	d.							TION OFFRONED	N MEDICAL		
9		Nedi	IE EEMALE.						CEKIRIO		1		
Box	death certific e attending p id for use as	an/I	Zob. was decedent pregnant	c. If yes, outcome 1 Live birth			Ectopic pregn	ancy				te of deliv	
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d		Other (specify				IVIC	onth	Day Year
J.	The law requires that the de ate has been signed by the apage 2 should be detached		Part II. Other significant conditions cont	ributing to death h	ut not resu	ulting in the ur	iderlying cause	given in Part	Ι.	23e. Did to	bacco use con	tribute to f	he cause of death?
Records,	signe d be o	d by	Hipe the rous	isn		g c.	,	g.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			es 2 No		bably 4 ☐ Unknown
Ö	w requires to be a signal should be a	lete	1- montion to	nes						24a. Was a	n 24h	Worn nut	opsy findings available
æ	he law e has ige 2 s	Completed	A P	1/1/11	1	2	<i>/</i> ) ·			autops perfor	med?	prior to co death?	impletion of cause of
Vita	sician; The la certificate he irector, page	a	25. Was case referred to medical	ced pro	NUY	(6)	tup-	26 Plac	o of Death	1 ☐ Yes ∩ (Check only or		1 ☐ Yes	2 ∐No
>	Physici this cer al direct	0.0	examiner? 1 X Yes 2 → No	spital:	ent 2 🗆	ER/Outpatien	t 3 DOA	Othor:		me 5 Resid		ner (Spec	fv)
0	ding Ph h. After th funeral	T:uc	27. Manner of Death  1. □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıry v. Year)	28b. Time of Injury	28c. l	njury at Vork?		28d. Describe h	ow injury occur	red	<del> </del>
Sio	Attendil death. ctor: A y the fu	catio	Thatural 5 ☐ Pending investigation  3 ☐ Suicide 6 ☐ Could not be	02/2010	)	Unknow	n M	l∐Yes 2 <b>X</b>		Subject			
Division of	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,	Certification: T	4 Homicide determined	28e. Place of Inj building, et			et, factory, offi	ce		28f. Location (S City or Tow	treet and Numb n, State) <b>50</b>	per or Run <b>Dut</b>	al Boute Number, Chman S
	pital ours a eral (		29a. Certifier 1 Certifying Physi	Nursing			occurred at th	e time date a					
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical Examin		of examina								
	To the within 2 To the complete	Me	29b. Signature and title of certifier					ense number		and the same of th	29d. Date signe	d (Month,	Day, Year)
			1 Tuff	Nood	MI			DOS	871	2	2/2	22/	10
			30. Name and address of person who cor	npleted cause of c	death (Item	n 23a) (Type,	Print)						
			William H. Wood Jr	., 501	Dutch	unan's	Lane, I	Easton	MD	21601			
	Sta Registr		31. Date filed (Month, Day, Year)  NAR 2 6 2010	32. Registr	ar's Signa	ture							
	negisti	EU.	<b>308 28 78</b>	F1.	- 6		0						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ruth Mills March 8 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2362 Gillis Road Mount Airy Carrol1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 M F 217-80-1586 92 Director April 18 1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner, must be notifled at 1 ☐ Yes 2 M No Director Md Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2362 Gillis Road 21771 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Tyes 2 No. Specify Specify: White 3 K Widowed 4 □ Divorced "natural", Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cook Madge James Drummond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: if Item 27 is any injury or other trau once. 2362 Gillis Road, Mount Airy, Md. Kim Shepard / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Cemetery 3/12/10 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 0 P. O. Box 5038, Laytonsville, Md. 20882 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final emen **Physician** disease or condition resulting in death) /Medical consequence of): Due to (or as Examiner elerium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated even resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by thrown 1 Yes 2 No 3 Probably 4 Unknown bri llation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Breas certificate 2 1No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 TYes 2 TINO 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 5 Residence 6 □Other (Specify) this 28a. Date of Injury 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? after death.

I Director: After the in by the funeral 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 139502 MD war

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State Registrar ed

31. Date filed (Month, Day, Year)

447, East Main sheet Westminster MD 21157

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

do

32. Redistrar's Signature

Hosain

MAR 10

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2.30 P.M 2 FRED MILES 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□F Months Days Hours Min 380-26-7319 78 June 24 1931 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes 2 XNo Md. Brookeville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 22014 New Hampshire Avenue 20833 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 No 1949-If Yes, Give Year or Dates: 1952 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify. 3 Nidowed 4 Divorced White Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber | 8 Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Miles Myrtle Likens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda M. Flaim / Daughter 22014 New Hampshire Ave., Brookeville, Md. 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Sucremation 3 ☐ Removal from State 3/13/10 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED disease or condition resulting in death) Due to (or as a consequence of): ORONARY TYPERTENSION Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 9□Unknown Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury

**Physician** /Medical Examiner

attending physician and for use as the burial-tran

signed by the a

peen

page 2 s

certificate funeral director,

this

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

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death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical Examiner

by

Completed

Be

Certification: To

Medical

**Funeral** 

Director

I and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. Sm 27 is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i shov any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

resulting in death) Last
IF FEMALE: 23b. Was decedent pregnant

 	9	 	,	
				•

25. Was case	referred	to	medical
examiner?			
1 ☐ Yes	20 No		

5 ☐ Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3□ Suicide

determined

28b. Time of 28c. Injury at Work? (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a. Certifier (Check only one)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Datę signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature USH 1-6 31. Date filed (Month, Day, Year)

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:10 P Elsie C. Miller March 13 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Garrett Oakland Nursing and Rehab Center Oakland If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 😾 F 85 04/20/1924 Director 578-28-0982 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Walfral Evanture 1, sat both titled at any Injury or other traumatic event, Item Walfral Evanture 1, sat both titled at any Injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 21 No Funeral Director MD 0ak1and Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1498 Garrett Road United States 21550 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2√□No Specify. Specify.White þ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ George T. Barnard Bertha B. Boyce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Altamont Road Swanton, MD 21561 Glen Miller, Son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2010 | Flintstone, MD Rocky Gap Cemetery 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signature of Funeral Service Licensee 21 N. Second Street Oakland, MD 21550 atherine VILLEITAGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 100 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes investigation 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

P.O. Box 68760 Division of Vital Records,

> State Registrar

4 Homicide

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

Thomas G.

29a. Certifier

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson,

2010

🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

311 N. Fourth Street, Oakland, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 1) 6

29d. Date signed (Month, Day, Year)

21550

		For State	State of Ma	aryland	-	partment o			lental Hy	- /		0	09545
		Registrar  1. Decedent's Name (First, Middle	le Last)			ertineate	oi Dea		2. Date of De	Reg. No.			3. Time of Death
Physicia		MYDIE M	- A	HUS					Month MARCH	12 Day	Op.	ear	10:00 PM
/Medic Examin		4a Facility Name (If not institutio			Homi	4b. City, Tov	vn, or Locati	ion of Death	MARKE		County of		1 - 1
	,	4101 CLD NAT	IONAL DIKE	21140	11 00.16	MOU	MT	AIR	4		AR	120	LL
Funeral		5. Social Security Number	6. Sex 7. Ag 1 ☐ M 2√2 F	je (In yrs. la		Months   D	ear If Un ays Hou	ider 24 Hrs. Irs Min.	8. Date of Bir (Month, Da	th ay, Year)	9	. Birthpla Country	ce (State or Foreig
Director		213-05-1237 Usual Residence of Decedent		92	Yrs.				Sept 4	, 19:	17   1	Mary.	Land
/land ow at		10a. State 10b. County	,	10c. City	, Town or	Location						100	d. Inside City Limits
a-f sh	tor	MD Carr	oll		Wes	tminster	:						1 Yes 2 No
ith the	Director	10e. Street and Number				10f. Zip Co	de			10g. Citi	zen of Wha	at Country	y?
after death with the Marylar or items 23a or 28a-f show miner must be notified at		15 Smith Ave					.157				SA		
items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Decedent Armed Forces?		3.   13	<ol><li>Was Decedent</li><li>If Yes, specify</li></ol>	of Hispanic Cuban, Mex	origin? (Sp kican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Black, 1	Americar White, et	
urs aff	by F	3√2 Widowed 4 □ Divorced	if Yes. Give	NO		1 ☐ Yes 2 ☐	No Spe	cify:			Specify:	Ta7b	ite
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ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	Coilege (1-4or	5+)	life	e. DO NOT use r	etired)	most of work	mig				
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should be filed within 72 hours after death with the Maryland not Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ဥ	John David  19a. informant's Name/Relations			19b. Ma	ailing Address (S	reet and Nu		lie Ann			ate. Zip C	Code)
and 2 ealth a n 27 Is		Joyce M. Harris	on Daught	er		mith Ave			ster, M		1157	,	/
es 1 a of Hei	İ	20a. Method of Disposition		20b. Pl	ace of Dis	sposition (Name or strematory or othe	of		Date		cation - Cit	ty or Tow	n, State
Pages ment of I ant: If Its ury or o		1 XBunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Bau		hurch Ce			/2010	_	one, l	_	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnoce.		21. Signature of Funeral Service	icense			22. Name and A	ddress of F	acility Pri	tts Fun	eral	Home	& Cl	hapel, PA
<u>σ</u> □ = α ο	-	Son Part Enter the disease	80	1 41 1 41-		412 Wash	ningto	n Rd.	Westmi	nste	r, MD	21	157
		23a. Part1. Enter the disease, o shock, or heart failure. Lis immediate Cause (Final	t only one cause on each li	ne.	. Do not e	enter the mode o	r ayıng, suci	n as cardiac	or respiratory a	arrest,		i	Approximate nterval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Or 9 Due to (or as			CARD	MC	FAI	LURE			F	our wesky
Examiner			LO RO			FRIER.	4 D	SEA	-F				Lean
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The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of	of delivery	,
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urs aft													
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the best i Examiner: On the basis of and manner st	of examinat	wledge, de tion and/or	eath occurred at a r investigation, in	he time, dat my opinion,	te and place , death occu	and due to the rred at the time	cause(s , date and	) and mann d place, an	ner as sta d due to t	ted. he cause(s)
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WIL		NB. Coll	anti				D.3	0469		MA	Rett	13	2010
W 30		30. Name and address of person	who completed cause of c	leath (Item	23a) (Typ	pe, Print)		7. 6	Colu		- L	K7 -	100
1 .		N. B. VELLANIA 8	1850, Colun	LIA 1	00 1	OKKWA	*	208	-5 /00	300	T , 59	12	1942

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death 2010 **Physician** 4:15 p M Barbara Paulette Matulevich March 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll 1253 Stone Rd. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days 1 □ M 2 □ ME Hours Min Nov 22, **Director** 197-34-0880 65 1944 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Carroll 28a-f MD Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 1253 Stone Rd. USA or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes 2 I 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 USPS Postal Worker marked other alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Alden Barlow Josie Blackburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1253 Stone Rd. Westminster, MD 21158 Paul A. Matulevich Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 Department of Important: If It any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/13/10 Finksburg, Maryland Evergreen Mem. Garden 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lic Westminster, MD 412 Washington Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Davi to (or as a consequence of) certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page perform certificate 1 ☐ Yes 2 1 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA P After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29b. Signature ter Street Westmister MU21157 -laviol nute mo

Registrar
DHMH 17 Rev 1/2001

State

Division of Vital Records P.O. Box 68760

		For State	State of	f Marylaı		artment of F		Mental Hygi	0.0	1.0	00017
		Registrar  1. Decedent's Name (First, Middle, L	ast)		Cel	Tillicate of	Deain	2. Date of Death	g. No.	-11	3. Time of Death
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/Med Exam		4a. Facility Name (If not institution, g			I VIV	4b. City, Town, o	r Location of Deatl		4c. County		3.72.
		DORCHESTER		RAL HO	PITAL	CAMB	RIDGE		DOR	CHE	STER
Funera	ı	Social Security Number     6.	Sex 1XM 2□F	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 12	Year)	9. Birthp	place (State or Foreign
Directo	r	215–30–8325	TIZM ZLIF	76	Yrs.			Nov. 12	, 1933		ýland
and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
Mary -f sh	ţ	MD Dorche	ster			C	ambridge				1 ☐ Yes 2 🙀 No
r 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	/hat Coun	itry?
th witi	ai D	1735 Dark Road					21613			USA	
r dea	Funeral	11. Marital Status	12. Was Dece Armed For	edent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-		e - Americ k, White, e	ean Indian,
s afte	by Fi	1 Never Married 2 Married	1 ∑Yes	2 No		1 ∐Yes 2 X No	Specify:		Specify	1	ite
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ges 1 and 2 should to f Health and Mer If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship Beverly Mulliki		wife	1		_	ridge, MD			Code)
s 1 an of Heal item 2		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of			0c. Location -	City or To	wn, State
permit. Pages 1 and 2 s Department of Health a Important: if item 27 is any injury or other trau		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec				natory`or other place 7 of Delmi		11/10	Delmar	, DE	1
permit. Departi Import any inj	á	21. Signature of Funeral Service Lice	ensee	·	22	2. Name and Addre	ss of Facility T	nomas Fund	eral Ho	ome P	.A.
	N N	the low	V					Cambridge		21613	
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e exe	E	resulting in death) Last	Due to (	or as a conse	quence of):						
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atten for us	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth 2 Fet nant at time of	al death 3 [	Ectopic pregnanc Other (specify)	у		23d. Dat	e of delive nth	ery Day Year
the do	Physi	1 □ Yes 2 □ No 9 □ Unknown	9 Unkn		July July						
The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	by Pł	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use contr	ibute to th	ne cause of death?
w requires been sign should be								1 ☐ Yes	s 2□No	3 ☐ Prob	oably 4 🗆 Unknown
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The tate has page	Som							autopsy perform 1 □ Yes 2	ed? c	leath?	
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Attending r death. ector: Afte by the fune	ifica	3 Suicide 6 Could not	ho i	of Injury - At h	lome, farm, stre	eet, factory, office	100 2	28f. Location (Stre	eet and Numb	er or Rura	Il Route Number,
s afte	Certification:	4 Homicide determine	buildir	ng, etc. (Speci	ity)			City or Town,	State)		
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the aminer: On the ba and mann	asis of examin	owledge, death ation and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and ma te and place, a	anner as s	tated. the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier		5	w/2	29c. Licens	e number	29	d. Date signed	(Month,	Day, Year)
11		JEEVAN E	RRABOLU	MD	U -		69234		3/0	9/2	010
12		30. Name and address of person who	_		m 23a) (Type,	Print)	بط	0 21/	13		
S	ate	31. Date filed (Month, Day, Year)		egistrar's Sign	ature	AMBRID.	12, M	D ~16	13.		
Regist		WAD 12 20		dead .	A. So	Mederal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death MShth MELVIN 2010 Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death SAUSBUR 1 COM/CO OICAL If Under 1 Year If Under 24 Hf 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 1 X M 2 □ F Months Days Hours Aug. 8, Year 958 Mary Land 51 214-70-5090 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 IISA 511 Mitchell Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 X Yes 2 No Years Black White etc 1 X Never Married 2 Married If Yes, Give Year or Dates. Unknown 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Laborer Construction 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) John William Melvin Sue Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Mitchell Street, Salisbury, MD 21801 Sue Dunn/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Crematory of Delmarva 3/10/2010 Delmar, Delaware Name and Address of Facility eller Funeral Home, P. 0 212 Old Ocean City Road, 21. Signature of Fineral Service 0. Box 3171 1, Salisbury MD 21802 a. Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List or Immediate Cause (Final Onset and Death resulting in death) Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) 23 25

Physician/ Medical **Examiner** Examine

Physician/

Medical

Examiner

**Funeral** 

Director

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ral", or items 23a or 28a-f sho Examiner must be notified at

"natural"

traumatic event, the Medical

2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "

permit. Page 1 and 2 should be Department of Health and Menl Important; If item 27 is marke any injury or other traumatic &

Director

Funeral

Completed by

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-transi and attending physician for use as signed by the a should has page 2 certificate filled in by the funeral director. this After 24 hours after death. Funeral Director: A

by Physician/Medical

Completed

Be ပ

Certificate:

Medical

29b

2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eccedent pregnant past 12 months?  as 2 No  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)  Nonth Day Year										
Part II. Other significant conditions PNEUMONIA	contributing to death but not res		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Tunknown								
				24a. Was an autopsy performed?							
25. Was case referred to medical examiner?			26. Place of Death (C	heck only one)							
1 Yes 2 INO	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗍	Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)						
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred						
3 Suicide 6 Could no 4 Homicide determine	200 Place of Injune At he		ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)						
29a. Certifier 1 Gertifying P	hysician: To the best of my know	ledge, death occured	at the time, date and place	e, and due to the cause(s)	and manner as stated.						

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

SKISBURY MID ZIBOY

3

29c. License number

H54827

State Registrar

completed

within 2.

2

. Date filed (Month, Day, Year, WAR 12 2010

(Check

only on

30. Name/and add

of person who completed cause of death (Item 23a) (Type, Print)

GITTELMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3<sup>Month</sup> Day **Physician** Sacah 201<sup>real</sup> Morgan 2.0'2149 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 32426 Black Forest Lane N.E. Little Orleans Allegany 3irthpla Country) PA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Sep 16, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** S. 1932 Months Days Hours Min 1 □ M 2√□ F 210-24-7386 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mast be multihed at 1 No 2 No Director MD Allegany Little Orleans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32426 Black Forest Lane NE 21766 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2√□No Specify þ Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/ 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked of ဥ Earl E Miller Mary W (Koones) Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Elliott daughter Rt. 1 Box 30 <u>Greenbank</u> WV 24944 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of the Important: If ite any Injury or of once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/2010 Prosperity Cemetery Flintstone MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has performe After this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical examiner?
1 → Yes 2 □ No director, Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and marmer stated.

DX

State Registrar

29b. Signature and title of certifier

Paul Snow M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number D09157

124 W. 3rd Street Cumberland MD 21502

29d. Date signed (Month, Day, Year)

22/10

as: Helen Nichols Chans

2

TO:0: 1145

Registrar

32. Registrat s Signature 31. Date filed (Month, Day, Year) 1 2 2010

MD

30 Name and eddress of person who o Robert Kaufman,

Neted cause of death (Nem 23a) (Type, Print) MD 300 West 9th St., Frederick, MD 21701

10-01984 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Kevin O'Brien State of Maryland / Department of Health and Mental Hygiene 010 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day March 10, 2010 Medical Examiner Michael Kevin O'Brien 1405 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 319 George Street Harford Bel Air 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours 1 XM 2 F Country) PA. 200-48-6746 49 March17,1960 Usual Residence of Decedent 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 Yes 2 X No Marylanф Harford Fallston hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2201 Watervale Road 21047 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2X No Yes 3 Widowed 4 N Divorced If Yes, Give Year 1 Yes 2 No specify. Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 honer of Health and Mental Hygiene.
ant: If item 27 is marked other than "roor other traumatic event, the Medical E Elementary/Secondary (0-12) d other than " College (1-4 or 5+) Baltimore. MD 21215-0036 -Salesman Auto Sales 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John P O'Brien Theresa F. Finnerty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) 19440 3109Arbor Green Court, Hatfield, Pennsylvania Thersa F. O'Brien/Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place)
Ardent Cremation 1 Burial 2 Cremation 3 Removal from State 3-12-10 Other Specify. Donation 5 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. Road, Baltimore, Maryland 212 6009 Harford 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Oxycodone and alcohol intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED 23a,27,28a-f, per ME g901 3/30/10 TT attending physician for use as the burial -Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If ves. outcome of pregnancy 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached 1 Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available cate has b autopsy prior to completion of cause of performed? death? After this certificate ✓ Yes 2 No 1 🗸 Yes 2 No or Attending Physician: after death. 25. Was case referred to medical director, 26.Place of Death (Check only one) Division of Vital å examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 Other: Scene 1 V Yes No 27 Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work Certification Natural in 24 hours after acan.
The Funeral Director: 5 Pending 1 Yes 2 X No Fd 1:30 pm Fd 3/101/0 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 319 George St Bel Alr, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be residence determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

State

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

**OCME** 

32. Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05<sup>Day</sup> 201 0 Physician/ O<sup>Mgnth</sup> 8:45 Рм Elizabeth Pancoast Palmer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Homewood at Crumland Farms Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Hours 97 143-16-9670 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7407 Willow Rd. 21702 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonidas Horner Pancoast Mary Smedley 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

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19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

SmithsburgCrematory 3/8/2010Smithsburg, 20c. Location - City or Town, State 1 Durilai 2 X Cremation 3 Removal from State 4 ☐ Øbnation 5 ☐ Other (Specify) f Funeral S'ervi e license ture <sup>2</sup>Donald ddr B. Frillompson Funeral Home RU POB 18 Middletown, MD 21769 Enter the disease, or on polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death hock or heart failure. List only Immediate Cause (Final Ph sician/ estive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I completed filled in by the funeral director, page 2 autopsy perform death? 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 X No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and itle of prtifier 0 D0055061 WEST NINTH STREET; FREDERICK, MD e of death (Item 23a) (Type, Print) 30. Name and address of person NAG AUBRIE MO 300 ar's Signature 31. Date filed (Month, 32. Regist State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lectreston Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Allegany 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
West Virginia May 3, 1934 212-38-5398 1 □ M 2 😾 F Months Days Hours Min. 75 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Barton 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23217 Potomac Hollow Road United States 21521 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: white Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housework Homemaker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harriet Parker Elton Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Preston/son 21521 23217 Potomac Hollow Rd, Barton, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 03/18/ Laurel Hill Cemetery Barton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home a 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death END STAGE CARDIOMYOPATHY Proysiciano disease or condition Medical resulting in death) Due to (or as a consequence of): MONTHS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year 1 ☐ Yes 2 Æ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CADISEASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown CHRONIC KIDNEY DISEASE Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🛛 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Willans D0065702 3/15/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Mor

AR'17 2010

Dr. Ravi Aiyer, 12501 Willowbrook Road, Cumberland, MD 21502

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

James Edward I	Phip	ps State of Maryland / Departmen 1-For State Certificate Registrar Certificate			ntal Hyg		2 0 eg. No.	10 09551
Physicia Medical Exami	an/ ner	Decedent's Name (First, Middle, Last)     James Edward Phipps				Date of Dear Month March 18,	th Day Year	3. Time of Death 0801 hrs
		4a. Facility Name (if not institution, give street and number) St. Mary's Hospital	4	b. City, Town, or Location Leonardtown	of Death		4c. County of St. Mary's	
Funeral Director		5. Social Security Number 220-17-8358 6. Sex 1 7. Age (In yrs. last birthda 36	yrs.	If Under 1 Year If Und Months Days Hours		8. Date of Bir		9. Birthplace (State or Foreign Washington Country) D.C.
ow any		Usual Residence of Decedent  10a. State						10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f sh	Director	10e. Street and Number 29911 Woodland Circle		10f. Zip Code 20659			Og. Citizen of What	t Country?
11. Marital Status 12. Was Decedent Ever			3. Was If Ye	Decedent of Hispanic Ori s, specify Cuban, Mexicar	igin? ( Spec n, Puerto Ri	ify Yes or No		American Indian, Black, etc.
nours after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	edenť	Yes 2 No specify. s Usual Dccupation (Give st of working life. DO NOT	kind of wor		Specify: 16b. Kind of Busir	White ness/Industry
.0036 within 72 h grene. her than "r Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Vorker				rkers Local#5
21215- vuld be filed Mental Hyg marked otl	To Be C	James B. Phipps	lailing :		icia	Harris		State. Zip Code)
e, MD ;		Jaymie L. Phipps/Wife 299  20a. Method of Disposition 20b. Place of Di	)11 isposit	Woodland Ci	rcle,	Mecha	nicsville 20c. Location - C	e, MD 20659
Baltimore, MD 21215-0036 pemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than nigury or other traumatic event, the Medic.		4 Donation 5 Other Specify:	Le1d	er place) 1—Echols Cre	m.	rch 23 2010	Charlot	tte Hall, MD F.H., P.A.,
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not en	301	.95 Three No	tch R	d., Ch	arlotte I	Hall, MD 20622
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Methadone intoxical due to (or as a consequence of):	tio	n and narcot	tic (n	orphin	ne) use	Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
ecuted and transit	I Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.						
be ex	Medical	IF FEMALE:  AMENDED  23a,27,28a-f,pe	erm	E, g901 3/31	l/10 1	TT .	23d. Date of de	livery
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Pregnant at time of death 5 Unknown	_	I death 3 Ectopio	c pregnanc	у	Month	Day Year
s, P.O. ires that the signed by the detached	ক্র	Part II. Other significant conditions contributing to death but not resulting in	the un	derlying cause given in Pa	art I.			te to the cause of deatn?  Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requints after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed					24a. Was a autops perform	sy prio med? dea	re autopsy findings available or to completion of cause of th?  Yes 2 No
Vital Rehysician: The this certificate	o Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpa	itient	26.Place of Death 3 DOA Other	(Check only		Residence 6	Other:
on of \ ending Phy anh. or: After th	<u>':</u>	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  28b. Time (Month, Day,Year)		1 Yes 2 X	28</th <th>d. Describe h</th> <th>ow injury occurred</th> <th></th>	d. Describe h	ow injury occurred	
Division Hospital or Attent 24 hours after death Funeral Directors tely filled in by the	Certification	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, (Specify) found at hor	street,			or Town, St chanic	treet and Number of ate) 29911	Rural Route Number, City Woodland Cir
Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or invessand manner stated.		n, in my opinion, death oc			and place, and due	to the cause(s)
	Σ	29b. Signature and title of certifier		O.C.M.E.			March 19, 20	(Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner	111	Penn Street, Baltimo	ore, MD	21201		
St	ate	31. Date filed (Month, Day, Year)  22. Registrar's Signature	Ke	1				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2010 Mary Chestnut Phillips March 1435 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days Hours July 8, 1928 Director 223-38-0585 81 Tennessee Usual Residence of Decedent f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland 1 🗆 Yes 2 🛣 No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1346 West Pulaski Highway 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: White 3 
 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fred Franklin Chestnut Effie Lee Brewer of Health and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Phillips, Jr./Son 1346 West Pulaski Highway, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. March 25. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Union Cemetery 2010 Union, MD Sign ture of Funeral Service Licensee 22, Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on entire. Interval Between Immediate Cause (Final Physicians CLEMI disease or condition resulting in death) day Medical Due to (or as a consequence Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 4 Pregnant Pregnant at time of death Month Day Year been signed by the should be detached g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 sl autopsy Leuna toid perform certificate AVIK 2 No Yes 25. Was case referred to medi examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours are Control of the Funeral Director: Aft Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar d address of person who

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

d cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	Amen	led	: 25,27,28a-per 1	e Type or Bri	26/28lack	<b>indeli</b> ble in	k. Ensure	All Copie	es Are Leg	jible.		
			for State Registrar	State of M		ertificate of		Mental Hy	/giene 2 ( Reg. No.	110	09	556
16	Physici Medi		1. Decedent's Name (First, Middle, L	Poul B	afferty			2. Date of Domestin		Year	3. Time of	
Ŧ	Exami	ner	4a. Facility Name (if not institution, gi	ive street and number)	e Centre	4b. City, Town, o	or Location of Dea	ath	4c. County	of Death .	·	
	Funeral Director		578-24-4069	Sex / 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday Yrs.	) If Under 1 Year Months Days	If Under 24 Hr Hours Min		rth ay, Year)	9. Birthplac Country)	ce (State or	Foreign
	fand show dat	ةِ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d	. Inside Cit	y Limits
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. if marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	VA HCCOr	nack	New	Church 10f. Zip Code	1		40.00		1 🔯 Yes	2 🗆 No
	is 23a	Funeral	33218 Ever	reen Di	rîve		3415		10g. Citizen of	What Country	7	
(0	er death or item niner n	by Fur	11. Marital Status  1  Never Married 2  Married	12. Was Decedent E		. Was Decedent of H If Yes, specify Cub.	Hispanic Origin? (§ an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Rac	e - American k, White, etc.		
21215-0036	urs afte tural",		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	942-1946	1 ☐ Yes 2 ☐ 4Ño	Specify:		Specify.		te	
215-	should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", aumatic event, the Medical Exan	Completed	15. Decedent's (Specify only highest of	grade completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of B	usiness Indus	try	
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lanc	be file lental H rked of	10 B	17. Father's Name (First, Middle, Last	. Raffer	rty Sr			ame (First, Middle,	Maiden Surname	)		
Maryland	should be file and Mental I is marked or raumatic eve		19a. Informant's Name/Relationship	(Type, Print)		ling Address (Street				tate, Zip Cod	e) <b>33</b> 3	37
	ie 1 and 2 s t of Health If item 27 or other tra		Joe Beacom 20a. Method of Disposition	Nephe		195 Wat	ts Bay	Drive	Wallops	Jolan	d.UA	
Baltimore,	Page nent c ant: If ury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		Occohano	ematory or other place		Date - 2010	20c. Location -		, State	
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lice	nsee		22. Name and Addre	-	3070	Chinco		UAS	3336
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	h sician/		shock, or heart failure. List only Immediate Cause (Final disease or condition		ivation,	oneum			1	Int	erval Betw nset and De	reen
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		iner	Sequentially list conditions, if any, cause. Enter Underlying	D. —	nonsequence of:	, A	to /	1/1		7		
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687	eath certificate be attending physic for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy		CEI	1				
D. Box 68760	g e g	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3 time of death 5	Ctopic pregnand Other (specify)			23d. Dat Mor	e of delivery hth Day	/ Ye	ar
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it	by	Part II. Other significant conditions	contributing to death but	at not resulting in the	underlying cause giv	ven in Part I.		obacco use contri Yes 2 No	bute to the ca		
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o uc	nding I ath. : After e funer	cate	27. Manner of Death  Natural 5 Pending 2 Accident Investigation	28a. Date of injury 02/2010// unknown	Year) injury	work			ow injury occurre		iple :	falls
)ivisi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	be 200 Blood of Injur	y - At home, farm, str (Specify)			28f. Location (S	treet and Number n, State) LVETBTEEI	or Rural Rou	ite Numbei	hurch
_	Hospita 24 hours Funera ted fille	Medical	(Uneck 2 L Medical Exam	ysician: To the best of miner: On the basis of exa	amination and/or inves	stigation, in my opinio	n death occurred.	and due to the cau	use(s) and manner	as stated.	V	A
	To the within 2 To the comple		only one) 3	rse Practioner: To the b	est of my knowledge,	death occurred at the	e time, date and pla	ace, and due to the	e cause(s) and mar 29d. Date signed	ner as stated.		TOI STERROG.
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	IVA		30. Name and address of person who	completed gause of dea	ath (Item 23a) (Type, I	Peninsu	la Rea	ional a	redical	(Ente	Sal	sburg
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kubin Month Blanche Year FNOCH 7.35P M Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital <u>Hagerstown</u> Washington Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign <sup>Year]</sup> 1924 1 □ M 2 🛣 F Months Hours Min. June 12 Director 217-12-9212 85 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Directo 1 Yes 2 XNo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19800 Tranquility Drive 21742 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72.1 and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cosmetician/ Sales Rep Cosmetics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Benjamin Enoch Fannie Lerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Haffner/daughter 5801 Box Elder Court Frederick, Maryland 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/16/2010 Woodbine, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD M009571 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death «Priysician/ adna aireine disease or condition resulting in death) Pialutie 6 moulu Medical Due to (or as a conse wince of): Examiner DOM-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending properties for use as IF FEMALE: es, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 S No Pregnant at time of death Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) မ 1 🔲 Yes 2 1 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 26 per Phy 03/12/2010 Carroll County, will
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2010 March 11, 9:18 p M Patricia Mary Runser /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster
If Under 1 Year | If Under 24 Hrs. Dove House 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 1 F New York Apr 25, 1929 Director 80 101-22-7023 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 28a-f Carroll Westminster 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 items 23a USA 21157 Funeral 612 Woodside Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ∐Yes 2√2 No Specify: δ 3 Nidowed 4 Divorced White "natural" Be Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Random House Telephone Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ William Gregg Charlotte Wolfe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 739 Eden Farm Cir. Westminster, MD James Runser son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 3/15/10 Hampstead, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service License 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerdoniucocia neudent Immediate Cause (Final Physician lwech disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a Was an autopsy performed? definentive just durance this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D31660 3/12/2010 NJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPILL News WESTMON STER MANYUTE 2:91 ITOMAS K-GALUN Ty 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State AMEND#22PerFH, 3/15/10, BMW, McCo 09559 Registra AMEND#3+30perMF, 3/15/10, BMW, McCr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March March 2010<sup>ear</sup> Jack Leon Rucker 7:30am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall VA Home St. Mary's Charlotte Hall Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Nov. 22, 1938 Days 1 XM 2 🗆 F Hours Director Iowa 480-40-5092 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 72 hours after death with the Maryland 10c. City. Town or Location Director MD St. Mary's 1 Yes 2 X No Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces? Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 If Yes, Give Year or Dates. 1962–1998 1 Yes 2 No Specify: Specify: White 3 Widowed 4XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Lieutenant Colonel Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude Pickett Paul Rucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 st partment of Health a portant: If item 27 is y injury or other tra John T. Rucker - Son 70 East 93rd Street, Apt. 2A, New York, NY 10128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of h Important: If ite 20c. Location - City or Town, State Post Cemetery 4-16-10 West Point, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Granby Sloan Funeral Service 4740 Granby Course 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 1092 Immediate Cause (Final Ph sician/ Onset and Death ARDIAC ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CEREBRO VASCULAR ACCIDENT Sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit executed Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MELLITUS Division of Vital Records, DIABETUS Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should THYPERTENSION ESSENTIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 2 🗆 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 40 Hospital: Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Hursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 tuw L MD 3.9.2010 D0067788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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31. Date filed (Month, Day, Year)

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Registrar's Signature

arstine.

29449 Charlotte Hall Road, Charlotte Hall MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>010</u> Month Physician/ 7:25P March 12, Thomas Francis Reid Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Montgomery Hospice Casey House 9. Birthplace (State or Foreign Country) New York If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days May 7 1 ★ M 2 🗆 F Hours 1951 **Director** 114-42-9732 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a USA 3510 Banquo Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 K No 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married within 72 hours after 21215-0036 1 ☐ Yes 2 🙀 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 3 Executive [ ] Be altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental ပ Alice Ricord James Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wendy Anne Reid/Wife 3510 Banquo Drive, Silver Spring, MD 20906 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Mar 14,2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J Collins Funeral Home Inc 21. Signature of Funeral Service Licensee al. Silver Spring, 500 University Blvd West, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? Year Month Day Pregnant at time of death ed by the a P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? director, page 2 should be det Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4  $\square$  Nursing Home 5  $\square$  Residence  $\bigcirc$ Other (Specify) HOSpice 2 😾 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 124 hours after death. e Funeral Director; After th Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R115108

Registrar

State

1355 Piccard Drive, Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

. Registrar's Signature

Diane Ruckert,

31. Date filed (Month, Day, Year)

March 14, 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3/12/2010 Day Carolyn Elizabeth Ruark 11:36 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8 / 6 / 1925 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country, 1 □ M 2 1 F 84 218-24-3989 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits 10h. County X□Yes 2□No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Purnell St. #29 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify. Specify: White 3 Widowed No Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) processor Holly Farms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Jones Lillie May Shirkey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Gray (grandaughter) 2825 Wakehurst Ct. Va. Beach. VA 23453 20a Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Makemie Cemetery 3/16/2010 Snow Hill, MD 21. Signature of Funeral Service Ocensee 22. Name and Address of FacilityThe Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ∐Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner P.O. Box 687

**Physician** 

**Examiner** 

Funeral

Director

show

Director

Funeral

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Be Completed

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ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, The Medical Examinat must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel

Department of Health a Important: If item 27 is 1 any Injury or other once.

Baltimore, Maryland 21215-0036

/Medical

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funeral director, After this Medical

Division of Vital Records, To the Hospital or Attenc within 24 hours after death To the Funeral Director:

> State Registrar

4  Homicide	determined
29a. Certifier (Check only one)	1⊠ Certifying Phys 2□ Medical Examin

Zecshan

29b. Signature and title of certifie

M·D

1XX Natural

2 Accident

3 Suicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1)0064120

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Benlin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGH 9733 Healthway

31. Date filed (Month, Day, Year) RAR 16 2010 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year M REBA ALICE STALEY MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) Funeral Days Hours (Month, Day, 1 □ M 2 🕱 F 1913 Maryland Director 96 216-22-7847 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 X Yes 2 No Frederick Walkersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>34 Main Street</u> 21793 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Bakerv ermit. Page 1 and 2 should be filed wi epartment of Health and Mental Hygie nportant: If item 27 is marked other by injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Silas C. Schildt Clara V. Hummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 116, Walkersville, Maryland 21793 Darlene Dowery/ Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3/13<sup>Date</sup>010 Department of I Important: If it any injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ridge Church of Brethren Rocky Ridge, Maryland eral Service 22. Name and Address of Facility Stauffer Funeral Home P. A. Opossumtown Pike, Frederick. Marvland21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit Exam law requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🛣 No Month Pregnant at time of death the detached Unknown 9 Unknown s been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page or Attending Physician: The certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 1 🗌 Yes 2 🗖 No ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De h 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Aatural 5 Pending 2 🗆 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of

-lugal

31. Date filed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

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			1 - State Registrar			Cei	rtificate (	of Dea	th	Re	g. No. 2 (	010	09563	
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Nancy E.	Stolt					:	2. Date of Death Month March	Day	Year 2010	3. Time of Death 18:55P M	
	Examin		4a. Facility Name (If not institution, give	· ·			4b. City, Tow		on of Death			ty of Death		
-			Montgomery Gener  5. Social Security Number 6. S		al e (In yrs. la:	né bisébalass	If Under 1 Ye	Olney	der 24 Hrs.	9 Data of Birth		ntgome		
Ċ.	Funeral Director			M 2 <b>M</b> F	86	Yrs.		ays Hou		8. Date of Birth (Month, Day, Jan. 26	Year) 1924		lace (State or Foreign try) nesota	
215-0036	Maryland -f show ied at	jor	10a. State 10b. County Md. Montg	omery	10c. City,	Town or Lo	cation ckvill	e	-			11	0d. Inside City Limits 1 ☐ Yes 2 No	
	with the	Director	10e. Street and Number				10f. Zip Co			10	og. Citizen o			
	ns 23	Be Completed by Funeral	14404 Gaines Ave	nue 12. Was Decedent B	Ever in IIS	13.3		20853	Origin? (Spe	cify Yes or No-		ed Sta		
	within 72 hours after death with the Maryland iene. than "natural", or Items 23a or 28a-f show he Mcdroll Exemple must be redfied at		Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates:				<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 □ Yes 2 ☑ No Specify:</li> </ul>				BI	Black, White, etc.  Specify: White		
	hin 72 hou e. an "natura Wooleal E		15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5	+)	16a. Dece (Give life.	dent's Usual O kind of work d DO NOT use re	ccupation one during i etired)	most of workir	ng	16b. Kind of	Business/Inc	dustry	
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Maryland	d be filed with ental Hygiene ed other that event, the		17. Father's Name (First, Middle, Last)  Albert Stolt							First, Middle, N, Erickson		ame)		
ary	should and Me s mark umatic	_C	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address (St			I Route Number,		n, State, Zip	Code)	
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	Pages 1 and 2 should be fi ment of Health and Mental F ant: If Item 27 Is marked ot ury or other traumatic ever		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specifi				sition (Name of matory or other Cemet		3/9		20c. Location Rocl	n - City or To kville		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	Back	4	22				Funeral		Md. 2	0882	
	Dhusisis	!	Onset						Approximate Interval Between Onset and Death					
	Physician /Medical		disease or condition resulting in death)  Circulatory  Due to (or as a consequence)											
	Examiner	-	Sequentially list conditions,	U	Hypotension  Due to (or as a consequence of):									
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	`	Severe Hyponatremia									
60,	te be executed ysician and e burial-transit		that initiated events resulting in death) Last	Due to (or as	Due to (or as a consequence of):									
287	certificate to ding physical se as the b	edical	•	Acute Renal Failure										
cords, P.O. Bo	atter for u	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1   Live hirth 2   Fetal death 3   Ectonic pregnancy					Date of delive Month	ery Day Year				
	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death and the c											
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a	sician: The lav certificate has rector, page 2								2 🗆 No					
>	ysicia is cert directe	o Be	examiner?	Hospital:	ent 2 🗆 F	B/Outpatie	nt 3 🗆 DOA	Others		n (Check only one		Other /Specif	iv)	
DIVISION OF	nding Phrth. r: After thi e funeral (	Medical Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?			2	tome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			<u>, , , , , , , , , , , , , , , , , , , </u>			
	To the Hospital or Attending Physician: The law within E4 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Spec			me, farm, street, factory, office 28f. Location ( City or To				28f. Location (St. City or Town	'Street and Number or Rural Route Number, wn, State)			
	ne Hospit n 24 hour ne Funera		29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							stated. the cause(s)				
	Vithii To th													
	5	hatalei Gronefan mo D 67275 March 6,						, 2010						
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Natalie Branagan, M. D. 18101 Prince Philip Drive, Olney, Md. 20832  31. Date filed (Month, Day, Year)  32. Registrar's Signature											
	Sta Registr		31. Date filed (Month, Day, Year)	0 2010	existed.	J. B.	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 04 201 0 1 Eugene Meredith Smith 6:30P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Kline Hospice House Mt. Airy 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 X M 2 □ F 3<sup>M9</sup>7<sup>2</sup>75<sup>3</sup>7 1<sup>2</sup>932 220-28-7938 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Frederick Jefferson 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 3950 Cherry Lane 21755 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than $\overset{\text{Elementary/Seconday }(0\text{-}12)}{12}$ College (1-4 or 5+) home builder construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or ဂ္ Floyd J. Smith Gladys Stockman 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*3950 CherryLane, Jefferson, MD 21755 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Doris Smith (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Stemeter More pelor) os other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/8/2010 4 ☐ Donation 5 ☐ Other Specify) Wolfsville, MD utheran Cemetery of Furferal Service 22. Name and Address of Facility Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 atur 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate ¢ause (Final Physician/ aspivation 1) neumon disease or condition resulting in death) ars Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a detached f 1 Yes 2 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy page death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospice Hous မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d Date signed (Month, Day, Year) 47/69 MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

		Please Type or Print in Black Ir State of Maryland / Dep			•				
	-	1 - State Registrar Ce	rtificate of Death	Reg	3. No. 2 0 1 0	00565			
Physicia	n	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3: Time of Death			
/Medic	al -	Pauline M. Savage	4h City Town or Location of Doot	March	16, 2010	5:19 A M			
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat  Oakland	ri	Garrett				
Funeral	e e	1205 Mack Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs	8. Date of Birth	9 Birthol	ace (State or Foreign			
Director		220-16-6870 1 M 2X F 83 Yrs.	Months Days Hours Min.	(Month, Day, Y 05/24/1		land			
pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10	Od. Inside City Limits			
laryla shov						ty⊡Yes 2 □ No			
the N 28a-1 notifi	Director	MD Garrett Oakland  10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	iry?			
3a or		1205 Mack Drive	21550		United Stat	es			
death	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puel	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e				
after amine	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☒ No Specify:		Specify:				
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	Whi 6b. Kind of Business/Ind				
in 72 n "na"	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of wo DO NOT use retired)	orking	bb. Ring of Basilesamia	asay			
d with giene. r thau	E	Elementary/Secondary (0-12) College (1-4or 5+)	memaker		Own Home				
al Hy l othe	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Ma	aiden Surname)				
Duld b Ment arkec atic e		Lester DeWitt	Amy	Wilson					
12 sh h and rism rraum			ing Address (Street and Number or R			Code)			
1 and Healt em 27		, 0	5 Mack Drive, Oak osition (Name of ematory or other place)	Date 20	21550 Oc. Location - City or To	wn, State			
ages ent of it: If it y or o		1 Kibunai 2 LiCremation 3 Li Hemovar from State	ematory or other place)   03/ County Memorial G	18/2010	Oakland, MD				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			22 Name and Address of Facility	<del>-</del>					
Der any		David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one of line.  Approximate interval Between							
Physician		Immediate Cause (Final disease or condition							
/Medical Examiner		resulting in death)  Due to (or as a consequence of):				1.0			
=Xammor	<u>_</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	U P D			georg			
uted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1			1 /			
executed an and rial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):							
ite be ysicia ne bur	ical	d							
The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	Physician/Medical	IF FEMALE:							
ath ce	jan/	23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delive Month	ry Day Year			
he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5	Other (specify)						
that the ded by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?			
quires n sign uld be	Be Completed by	Valuly Ven	+dtjern	1 ☐ Yes	s 2 No 3 Prob	ably 4 □Unknown			
s beel		+100		24a. Was an		psy findings available			
The la		, , , , , , , , , , , , , , , , , , ,		autopsy perform 1 Yes 2	ed? death?	npletion of cause of 2□ No			
strifica ctor, p		25. Was case referred to medical examiner?	26. Place of De	eath (Check only one					
Attending Physician: death. ector: After this certifica by the funeral director, i	일	1 ☐ Yes 2☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			nce 6 Other (Specify	)			
Ilng P	ion:	27. Manner Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred				
death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s		28f. Location (Stre	eet and Number or Rura	l Route Number.			
after Dire		4 Homicide determined building, etc. (Specify)							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	SalC	29a. Certifiler (Check only (Check only 1) Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place	ce, and due to the car	use(s) and manner as st	tated.			
the Ho in 24 the Ft	edical	one) and manner stated.							
To t To t	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)			
		71	01335		2/16/10				
	5	30. Name and address of person who completed cause of death (Item 23a) (Type		d. MD 215	50				
⊸ Sta	te_	Dr. Thomas G. Johnson, 311 N. Fourt  31. Date filed (Month, Day, Year)  32. Registrar's Signature	1, FID 213	JU					
Registr	_	MAR 18 2010 - A.	park						
HMH 17 Rev 1/20	001		'/						
		0	RIGINAL						

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month William Edward Stevens 3/13/2010 5:38 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Worcester 9. Birthplace (State or Foreign Country) Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Min. Days \* M 2□ F 82 Months Hours 579-30-9953 USA 1/15/1928 MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h. County 1 X Yes 2 □ No Worcester Ocean City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 106 A 120th St. 21842 IIS A 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TrNo Specify. If Yes, Give Year or Dates Specifywhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) management Bell Atlantic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edward Stevens Alelia Houston Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Stevens 106 A 120th St. Ocean City, MD 21842 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5 ☐ Other (Specify) 3/15/2010 Frankford, DE 4 □ Donation Cape Henlopen Crem. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Extr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if hear failure. List only one cause on each line. Approximate Interval Between Onset and Death neumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 ☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

28a-f show

23a or

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filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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other traumatic event, the Medical Examiner must be notified at

burial-trar physician s the burial attending pl cate has been signed by page 2 should be detach

Physician/Medical

\$

Completed

Be

27. Manner of Death

1 Natural

3 Suicide

29a, Certifier (Check only one)

2 Accident

4 Homicide

29b. Signature and title

Medical Certification: To

After this certific funeral director,

Vital of Division Hospital or Attending filled in I 24 hours a

9+1 State

within 2

31. Date filed (Month

5 Pending investigation

6 Could not be determined

of certifie

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANALY CO. F. SWEY, MP 9733 He MD 9733 Healthway Dr. Berlin, MD 21911

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28a. Date of Injury (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#3perMD, 3/16/10, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1445 homas 03 10 MAGGIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomer) Bethes Ja Heath & Rehabilitation (ntv 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M Months 575-46-8126 Usual Residence of Decedent Director 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the insertional partition and injury or other traumatic event, the insertical Expression and the notified at 1 XYes 2 No Director Montgomery MD 10g. Citizen of What Country? 10e. Street and Number 9505 20910 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2X No Specify: ò 3 ☐ Widowed 4 ☐ Divorced BKCK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dasie ဂ Dave Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas 9505 HallPi Silver Spring, mo 20910 (Husbana 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State IMD Veterans Cemetery 03/3/110 (heltenham, mo 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The House of 21. Signature of Funeral Service Licensee 4804 Georgia Aug. NW. Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Life of deriving Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Year Day 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 2 PNO 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2 Mo Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending To the Hospital or Autonomics within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lu Ben, uno 00057124 3/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bao 10110 Molecular Dr. Rockuille IMD 20850 31. Date filed (Month, Day, Year) MAR 15 2010 State mus. Registrar

een Onset and

Death

24b. Were autopsy findings available

death?

1 🗸 Yes

29d. Date signed (Month, Day, Year)

March 16, 2010

prior to completion of cause of

2 No

Physician/Medical AMENDED 23a, PII, 27, permE, g901 3/31/10 TT XUNPENDED the attending physician hed for use as the burial IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be deta 2 1 Yes 2 V No 3 Probably 4 Unknown Hypertensive cardiovascular disease Completed has been s 24a Was an autopsy performed certificate ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other | Nursing Home 5 Residence 6 Other DOA this 1 V Yes 28a. Date of Injury (Month, Day, Year) After 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural 1 Yes 2 No d in by the Pendina Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide To the Funeral F determined (Specify) Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

31. Date filed (Month, Day Yea State Registra

29b. Signature and title of certifier

Donna M. Vincenti, MD

OCME

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Division of Vital Records, P.O. Box 68760

10-02112 Robert Woolford

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

CODEIL WOOHOIG		1- For State  Certificate of Death  Reg. No. 20	0 09569					
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death	3. Time of Death					
Medicai Examii	lei	Robert Nathaniel Woolford March 15, 2010  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of						
		Memorial Hospital Easton Talbot						
Funeral Director		213-60-9473 1 MM 2 F 56 Yrs. Months Bays 10013 MILL Aug. 12, 1953	9. Birthplace (State or Foreign Country) May 4 land					
yna	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
h .	5	MD Talbot Easton	1 Yes 2 No					
Maryli r 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What	Country?					
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner, must be notified at once	a l	10 Village Street Apt. 24 21601 25  11. Marital Status J 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race -)	American Indian, Black,					
leath w	Funeral	1 Never Married 2 Married 2 Married 1 Yes 2 No						
after c	by F	or Dates:	Black					
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Busin	ness/Industry					
036 ithin 73 ne.	Completed	Dishwasher Resta	iuran+					
			1					
2121 uld be fil Mental H marked	10 Be	Levin Woolford Gladys Harri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rute Number, City or Town,	State Zin Code)					
C 등 등 등 등			ary land 21601					
re, MC s 1 and 2 si f Health ar if item 27		20a. Method of Disposition  20b. Place of Disposition (Mame of cemetery, Date 20c. Location - C crematory or other place)						
Baltimore, permit. Pages 1 ar Department of He Important: If ite	Ц	4 Donation 5 Other Specify: Hughes Chapel (emetery 3/20/10 Cambr.	dae, MD.					
Baltimo permit. Page Department o Important: injury or ott	1	22. Name and Address of Frility  Henry Funeral Hone, P. Ar	- 4/0 01/ (3					
Physician	1	23a. Pan I. Enter the disease, or complications that can ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or man	Approximate Interval					
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	Between Onset and Death					
LXGIIIIICI		or condition resulting in death)  Due to (or as a consequence of):						
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
cuted	ă	d.						
D, be exe sician s	<u>ğ</u> [	d. UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of de						
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and sinneral director, page 2 should be detached for use as the burial - transil -	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Day Year					
the de	준	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	te to the cause of death?					
, P.O. res that the signed by be detach	ğ	1 Yes 2 No 3 🗸	Probably 4 Unknown					
Division of Vital Records, tal or Attending Physician: The law requirers after death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be a been sited in by the funeral director, page 2 should be a should be a second to be a should be a second to be a should be a second to be	Completed	24a. Was an 24b. We autopsy prio	re autopsy findings available or to completion of cause of					
Reco The law icate has	Ē	performed? dea						
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?						
Physic Physic er this rral dire	잂	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 C. R	Other:					
ion of tending Pheath.		1 Natural 5 Pending (Month, Day, Year)						
ViSic or Atte fler dez Directo	Certification	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Council Place)	or Rural Route Number, City					
Diversity of filled	3	4 Homicide determined (Specify) or Town, State)						
8 - 5		29a Centher						
To t with To tl	Medical	and manner stated.	(Month, Day, Year)					
N		O.C.M.E. March 16, 20	10					
7	30. Na and addres person who completed cause of death (Item 23a)							
V		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
Sta Registr	te	31. Date filed (Month, Day Year) 2010 2. Registrar's Signature						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09570 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Catherine Shirley Wheeler 2010 10 9:14 a. M March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1302 Race Street Dorchester Cambridge 8. Date of Birth (Month, Day, Dec. 28, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 1 □ M 2 □ M Months Days Hours 215-24-0913 82 Dec. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location Dorchester Cambridge 1 Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1302 Race Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3 □ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) switchboard operator telephone 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Smith Clara Belle Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Ann Wheeler daughter 1302 Race Street, Cambridge, MD 21613 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 3/15/10 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 21. Signature of Funeral Service Lie 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final End Break- Concer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 E N 2 CH

**Physician** /Medical Examiner

death certificate be executed

Box 68760.

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Physician:

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To the Hospital o within 24 hours aff To the Funeral Di

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

MD

**Funeral** 

Director

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Health a

permit. Pages 1 and Department of Health Important: If item 27 any injury or other thoronce.

Maryland 21215-0036

Baltimore.

Examiner Physician/Medical Completed by

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Medical Certification:

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No. 9 Unknown

3-10-10

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | 4No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work?

27, Manner of Death 1 Natural 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 D Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only one) and manner stated 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY 503 BYRN CAMBRIDGE

17924

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10a-c, e-f, per Fh g902 4/26/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 3/11/2010 Day Elsie Louise Marie Walsh 6:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20 Chatham Court Worcester Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 94 Days Hours Min. 6/17/1915 Sear) 139-10-9387 **Director** Yrs. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Monmouth HD NJ 1 Yes 2 No Berlin Ocean Worcester 10e. Street and Number 15 Griffin Place 10f. Zip Code 10g. Citizen of What Country? 20 Chatham Court 21811 07712 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r 1Etementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Allen Madeline Ehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trat once. Pat Addy (daughter) 20 Chatham Ct. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gertrudes Cemetery 3/17/2010 Colonia, NJ 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 21. Signature of Funeral Service Licenses 23a. Part 1 Enter the discusse, or complications that caused show, or heart fail e. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Carotia artem stenosis, severe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia, end-stage 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed 2 🗌 No Yes 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 D Nursing Home 5 Residence 6 D Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier angela Gibbs up DO066169 03/12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Givis, MD 10445 Old Ocean City Blud #1 Berlin, MD ZIBII 20 31. Date-filed (Month, Day, Year) State MAR 1 6 2010 Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 11, Day 2010 Year Physician/ 4:45 p M Rosemary W. Woolson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery National Lutheran Home Rockville Social Security Number 578-34-0577 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Nov. 14. 1929 Months 1 □ M 2🛣 F 80 Days Hours Country) Vrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🏝 No 28a-f Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a Funeral 20715 USA 13101 Steeplechase Drive event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Federal Government Be 1 and 2 should be filed f Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William G. Wagner Lillian E. Burrows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Christy E. Gordon/Daughter 15 Oak Shade Road, Gaithersburg, other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date permit. Page 1 a Department of I Important: If its ð cemetery, crematory or other place) March 2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Parklawn Memorial Park Rockville, Maryland 4 Donation 5 Other (Specify) injury <sup>22</sup>Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses anyi Inc. Spring, MD 2090 MO1503 23a. Part Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be 68760 attending p IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death signed by the a 1 ☐ Yes 2 ¥ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death byt not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? cate has 2 No certificate 1 Tes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, **Division of Vital** Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29b. Signature and title of certifier 29c. License number

State Registrar VEIRS DRIVE,

9701

. Registrar's Signature

KOCKVILLE, MD

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09573 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 815 M MARCH 2010 Donald V. Walker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/8/1928 Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 X M 2 □ F 82 NΥ 074-22-5800 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show **Funeral Director** 1 ☐ Yes 2/ ☐ No Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code DDC: 1|8|2% DDD: 3|11|10 Baltimore, Maryland 21215-0036 7 Bay St. USA 21811 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ If Yès, Give Year or Dates: 2 No 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: Completed by 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Photographer Photography 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Craighead Walker Dorothy VanderVeer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Healti Important: if Item 27 any injury or other tra once. 7 Bay St., Berlin, MD 21811 Anne VonSchilgen / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/12/2010 | Frankford, DE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death immediate Cause (Final neumonia **Physician** Aspiration disease or condition resulting in death) /Medical Due to (or as consequence of): **Examiner** Septre Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Renal Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Atrial Fibrillation Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Chronic Obstructive ulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No ispital or Attending Physiclan: In hours after death.
Ineral Director: After this certificat it filled in by the funeral director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11 MAR 2010 who completed cause of death (Item 23a) (Type, Print 30. Name and address Healthway Dine Berly, MD 21811 Hamnas, MD

State Registrar

MAR 1 5 2010

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55# 1714-72-580

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Wilma Grace Younkin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Regional Medical Center Cumberland Allegany 8. Date of Birth (Month, Day, Yea March 24, Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 🗆 M 2 😿 F Maryland Yrs 1920 Director 196-18-2314 89 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 351 Shade Hollow Rd. USA 21536 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lydia Wisseman Wilson E. Miller other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is 12611 Woodbine SW, Cumberland, MD Marilyn Crowe/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State injury or Grantsville Cemetery March 18, 2010 Grantsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Liv any P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) purs Medical Due to (qu Examiner cul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events to C resulting in death) Last physician a Physician/Medical ours Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law nas autopsy page 2 performed? Yes 2 No certificate 1 Yes an No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and file of certifier 29d Date signed (Month, Day, Year) 066604 Maryland health System, 12500 willow brook s of person who completed cause of death (Item 23a) (Type, Print) West 31. Date filed (Mo

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death		8. Time of Death 3 3:15 p M			
	Medic	al :	Margaret Mary Zahn  4a. Facility Name (if not institution, give street and number)		4h City Town or	Location of Death	<u> </u>	4c. County of Dea				
	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital					Spring		Montgome	1			
Ī	Funeral Director		578-10-1126 1□M2 <b>X</b> F 95	(In yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Sept. 25	(ear) 9. Bii Cc	thplace (State or Foreign) ountry) D • C •			
	and show I at	ě	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
	Maryli 28a-f otifiec	Director	Maryland Montgomery	Silve	r Spring				1 ☐ Yes 2 🛣 No			
	th the	al D	10e. Street and Number 1026 McCeney Avenue	-	10f. Zip Code 20901		10	Og. Citizen of What C	ountry?			
	ath wi	Funeral	11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. V		ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian.			
036	s after de ral", or ite Examiner	by	1  Never Married 2  Married 1	Vo.	Yes, specify Cuba  ☐ Yes 2 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc.			
2-0	2 hour "natu dical	plet	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup	ation during most of work	ing	16b, Kind of Business	Industry			
12	thin 7 ene. than he Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+	h) <b> </b>	O NOT use retired) maker			Own Home	•			
<u>م</u>	led wi I Hygie other ent, t	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Mi	aiden Surname)				
<u> </u>	d be filed Mental Hyy arked oth	욘	Samuel P. Evans			Nellie	A. O'Sul	livan				
, Maryland 21215-0036	and 2 should be Health and Ment tem 27 is marked other traumatic e		19a. Informant's Name/Relationship (Type, Print) George E. Zahn/Son	19b. Mailin <b>90</b> 9	g Address (Street a	and Number or Run Avenue, R	al Route Number, ( ichmond,	City or Town, State, Z VA 23227	ip Code)			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Gate of	natory or other plac	:e) M	larch 18	20c. Location - City o	r Town, State ing, Maryland			
Balt	permit. Departimport any inj	( ) ( )	21. Signature of Funeral Service Licensee	22. 5	Name and Addre Francis OO Unive	s of Facility Collin rsity Blv	s Funera	l Home Inc	ing,MD 20901			
			23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
	hysician Medical	ő d	Immediate Cause (Final disease or condition resulting in death)  a. Ischemic Bowel Disease  a. Due to the company upper off:									
	Examiner		Due to (or as a consequence of):  Sepsis									
		ner										
5	cuted nd transit	Examiner	Cause (Disease or iinjury that initiated events C. Acute Re	enal Failu	re							
	cate be executed physician and the burial-transit	alE	resulting in death) Last Due to (or as a	consequence of);								
220		ledic	d									
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death.  Within 24 hours after death.  Other Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to complete filled in by the funeral director, page 2.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   S No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of   Month   Month   1   Yes   2   S No   9   Unknown   9   Unknown   1   Nonth   Nonth   1   Nonth   Nonth   1   Nonth   Nonth   1   Nonth   Nonth   1   Nonth   1						elivery Day Year			
<u>о</u> .	hat the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									
l, St	puires f	ed b	Acute G.I. Bleed due to Ischemic Colitis, 1 - Yes 2 No 3 -									
Sor	aw red as bee 2 shor	Completed	Diabetes Mellitus-Type II, Congestive Heart Failure,  24a. Was an autopsy prio						utopsy findings available completion of cause of			
Re	The la	Con	Hypothyroidism, Peripheral	Vascular	Disease		perform 1 \sum Yes 2	ned? death? No 1 ☐ Ye	es 2 🙇 No			
ital	sician certifi rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital:		Oth	ace of Death (Chec	-	- C				
of V	y Physer this eral di	e: To	27. Manner of Death 28a. Date of injury		28c. Injur	3 L DOA 4 Nursing Home 5 L Resider  28c. Injury at 28d. Describe how						
ono	ending sath. or: Afte he fun	ficat	1 Matural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	; Year) injury	work? M 1 ☐ Yes 2 ☐ No							
Division of Vital Records,	al or Atto s after de I Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, stre . (Specify)			28f. Location (Str. City or Town,	n (Street and Number or Rural Route Number, Town, State)				
_	e Hospit 24 houn e Funera	Medical	29a. Certifier (Check conly one)  1 Certifying Physician: To the best of responsible to the basis of examiner: On the basis of examiner to the basis of examiner.	amination and/or invest	tigation, in my opini	on, death occurred a	at the time, date and	d place, and due to the	cause(s) and manner stated.			
	To th within To th comp	_	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Mon				
	12		Barbara Suparich RSW MD D0065485 03/12					3/12/2	010			
			30. Name and address of person who completed cause of de Barbara Supanich, MD 150	eath (Item 23a) (Type, F O Forest G	Print) len Road	, Silver	Spring,	MD 20910				
	Sta Registr	te ar	31. Date filed (Month Pay, Year) 33. Registrat	r's Signature	Med.							

10-02342 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Aaliyah Akingbade State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 1624 hrs March 23, 2010 AALTYAH AKINGBADE 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Doctors Community Hospital** Prince George's 5. Social Security Number 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** oreignLandover. Months Days Hours Director Country)MD 1 M 2 X F 12/21/2009 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Landover Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 2408 Virginia Ave. # 203 20785 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nekole Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oladano Akingbade 19a. Informant's Name/Relationship (Type, Print) Nekole Williams / Mother 20a Method of Disposition 2408 Virginia Ave 20b. Place of Disposition (Name of cemetery, #203 Landover, MD 20785
Date | 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 3/31/2010 Clinton, Maryland <u>Resurrection</u> 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Linensee 1 Dankin 5538 Marlboro Pike Forestville, Maryland 20747 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each Medical Death Immediate Cause (Final disease Sudden infant death syndrome Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a,27,per ME G903 5/26/10 TT X UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Ectopic pregnancy Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed has been si 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy nerformed? death? page certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: DOA this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Director: d in by the f 1 Yes 2 No Pending hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 24, 2010 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar Signature

Melissa Brassell, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 5:04P M 2010 Gloria Janet Allen /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BAltimore City Baltimore of SINAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 OHIO 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 TF 302-30-6799 Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Express must be notified at 1 □Yes 2 No MD Director IKESVILLE 10e. Street and Number 10g. Citizen of What Country? Hollow 21208 U.S.A. by Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: BCACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 1 Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL NURSE Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be BLACKWELL DOROTHY M. RICHARDSON ပ of Health and M 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) Bishop Keith G. AllEN 3403 Birch Hollow Road, PIKESVIIIE, MARY HAND 21208 HUSHAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 31/2010 4 ☐ Donation 5 ☐ Other (Specify) BALFIMORE, MARYLAND 22. Name and Address of Facility The DERRICK C. JOINES, FIH, P.A. 21. Signature of Funeral Service Lica 4611 PARK Hats. AVE. BAITIMORE, MARYIATION of enter the mode of dying, such a cardiac or respiratory arrest,

Apploximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metasTATic CANCER CERVICAL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to for se's consequence or; Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): led by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year Pregnant at time of death 5 Other (specify) 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation after death Director; 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054558 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK J. BURKE, JR, MO S. of BAltimore SINAL HOSPITAL Ragistrar's Signature 31. Date filed (Month, Day, Year) State

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DHMH 17 Rev 1/2001

Registrar

Sinve S. park **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sarah J. Baum March 26, 2010 P 5:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c, County of Death 815 Winters Lane Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 9/18/1925 1 M 2 XF Months Hours 218-22-7597 Director 84 Pennsvlvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 X No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral e filed within 72 hours after death with 815 Winters Lane 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 X No ģ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 X Divorced White Year or Dates Page 1 and 2 sho I/d e filed within 72 hours ment of Health anc Mental Hygiene. ant: If item 27 is r arked other than "natur ury or other traum atic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Jewelry Marker Retail Jewelry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Petro Matastasio Antimarie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8415 Berkfield Road, Rosedale, Maryland 21237 Michael L. Baum / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 3/29/10 Baltimore MD 5 Other (Specify) 4 Donation 21. Signature peral Service Licensee 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Balto MD Essex 21221 23a. Part 1. Enter the disease implications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List of v one cause on each lin Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsecuence of Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed certificate 2 🗆 No Yes 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 31 Certifying Nurse Practioner: To the amed at the time, date and place, and due to the cause(s) and manner as states 29b. Signatura and title of certifie 29c. License number My)

DHMH 17 Rev 7/2009

State Registrar 30. Name and

31. Date filed (Month, Day, Year)
MAR 3 0 2010

vederick

dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0951 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day  $A^{M}$ **Physician** 2010 March 26, 9:22 Carol Rigo Bounds /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Cherry Lane Nursing & Rehab Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea. 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 □ M 2 🔀 F New Jersey 31, 1941 68 July Director 214-42-5081 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours after death with the Marylar al Hygiene.
tother than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20707 15605 Darwin Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NSA College (1-4or 5+) Elementary/Secondary (0-12) 3+ U.S. Government GS-14 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil and Mental H ' is marked otl Be Helen Therese Muller Charles Paul Rigo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 270 Washington St., Harpers Ferry, WV 25425 Therese R. Alexander (Sister) Health tem 27 i Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of F Department of Important: If It any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 3/26/10 Alexandria, VA 4 □ Denation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup> Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 21. Sig ture of uneral Serv Linnser lennie Tillaure 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 Months **Physician** Cancer of Lung with Metastasis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 2**7** No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 2 ER/Outpatient 3 DOA ပို this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation after death.

I Director: / 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral of the Inc. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and title of certifier 5 70

30V

State Registrar

14333 Laurel Bowie Rd., Laurel, MD 20708 Syed Akbar Sadiq, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D24721

March 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Mildred L. Bentz 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Riverview Nursing Center Essex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K Months Hours 88 213-14-3582 Director 192 Aug.6. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notifled MD Baltimore Essex 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 Funeral 312A Savannah Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Esskay 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie L. Bass Barbara E. Grebner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda McCoach /DAughter 1301 J CloverVallyWay Edgewood MD 21040 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly, Hill 10 Cemetery 3/30/10 Baltimore MD 4 Other (Specify) 21. Signarur Funeral 8 vice License 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Balto MD Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown Ö þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No certificate 24 hours after death.

Funeral Director: After this certifica eted filled in by the funeral director, proceed the filled in by the funeral director, proceed filled in by the funeral director filled in by the funeral director, proceed filled in by the funeral director filled in by the funeral direct 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) No 🂢 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1XNatural 5 Pending work Division 1 Yes 2 No Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a, Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D619 OI

DHMH 17 Rev 7/2009

State Registrar Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ Brook heodore 10 PM Medical Facility Name\_(if not institution, 4c. County of Death Examiner Town, or Location of Death ete 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months **Director** "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items be notified at any litury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?
Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation Kind of Business Industry Give kind of work done during most of working fee DO NOT use retired) (Specify only highest grade completed) Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Baltimore, 266. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation 3 Removal from State Ignature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyl shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Malipuen disease or condition resulting in death) neop Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in reclaim cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should peen 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 2 🔀 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) oure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew och Raven Baltimore MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician MYRTLE JEANETTE BURCHAM 25 MARCH 2010 9:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1417 Overlook Way Bel Air Harford Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Months Hours 1 M 2 X F Director 213-28-6379 78 May 1, 1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f sho event, the Medical Evanger must be rediffed at 1 ☐ Yes 2 No Directo Harford Maryland Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1417 Overlook Way **USA** 21014 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. \$ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) <u>Test Scheduler</u> U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne Edward Cheek Jane (unk) Yale ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is 1
any injury or other trau Pervis C. Burcham Jr. / Husband 1417 Overlook Way, Bel Air, Maryland 21014 Baltimore, Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion U.M. Chr. Cem. 3-28-10 Bel Air, Maryland <sup>22. Name and Address of Facility</sup>
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Sign 1 of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IN COED DO **Physician** /Medical Due to (or as a consequence of): Examiner WOUND Ecquentially fiel conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of): burial-Box 68760 attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.0. the 9 I Hoknown 9 Unknown by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home '5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification; 27. Manney of Death 28d. Describe how injury occurred Injury at Work? **Hospital or Attending** 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral hours

State Registrar

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the

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DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of c

Huzefa Bahrain, D.Q

and manner stated.

32. Registrar's ignatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

9110 Philadelphia Road, Baltimore, MD 21237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-02363 State of Maryland / Department of Health and Mental Hygiene Joseph Harrison Babcock Certificate of Death 1- For State Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1707 hrs Harrison Babcock March 24, 2010 Medical Examiner Joseph 4b. City, Town, or Location of Death c. County of Death 4a, Facility Name (if not institution, give street and number) St. Marv's Lexington Park 46905 Lei Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Country)Wash D.C Months Days Hours Aug 24, 1954 55 Director 228-78-5574 1XM Usual Residence of Decedent 10d, Inside City Limits Oc. City, Town or Location 10a. State ē Ob. County 1 Yes 2 No Lexington Park MD Saint Mary's permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20653 46905 Lei Drive 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specity Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 Never Married 2 Married Yes White 1 Yes XX No specify: 4 X Divorced If Yes, Give Year ⋧ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Contracting Electrician timore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beverly Jo Henry Babcock, Sr. Be William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ٩ 8063 Green Orchard Rd, Glen Burnie, MD 21061 Ms. Jennifer Weigman/Daughter 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License MO1580 Services, PA 1 2nd Ave., SW Glen Burnie, MD 21061 28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia complicating Chronic obstructive Approximate Interval Physician Between Onset and /Medical Death Seizure disorder pulmonary diease (COPD) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transit XX AMENDED 23a, per ME g905 7/2 23a, 27, per ME g903 5/ Physician/Medical X UNPENDED Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Completed 24b. Were autopsy findings available After this certificate has been in uneral director, page 2 should 24a, Was an prior to completion of cause of autonsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26 Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient FR/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 2 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 X Natural 1 Yes 2 No Pending Director: Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 24 hours a Funeral I determined Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated.

State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

29b. Signature and title of certifier

Pamela E. Southall, MD

outhall, MI 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Yamen 9

31. Date filed (Month)

arke

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Day 26 **Physician** Samuel Robert Bull March 2010 6:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 24, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) Funeral Days Year) 32 Director 218-26-2746 77 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner roust by notified at 1 ☐ Yes 2 ☐ No Director Baltimore Owings Mills MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Is marked other than "natural", or items 23a USA 12329 Greenspring Avenue 21117 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No þ Specify: 3 Widowed 4 Divorced white Completed Item 27 Is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Freight Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Thomas E. Bull Grace Wisner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any Injury or other traum once. / wife 12329 Greenspring Avenue; Owings Mills, MD 21117 Lorraine E. Bull 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Çremation 3 Removal from State 4 Donation Other (Specify entonoment Dulaney Valley Mem Gardens: 3/29/10 Timonium, MD 21. Signature of Fundral Service Icense 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one care on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 35 years **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and i be detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen si should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has t funeral director, page 2 s autopsy performe 1 ☐Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Al completely filled in by the fur NA death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier t 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number

Registrar

31. Date filed (Month, Day, Year) State MAR 30

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 Day Physician/ March Diane Τ. Bach 2010 7:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist . Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In vrs. last hirthday) July 14 Hours Min. 1 M 2 XF 1928 81 Maryland Director 214-26-0691 Usual Residence of Decedent items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Towson Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21286 619 Fairway Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. and Mental Hygiene. is marked other than "natural", or \$ 1 Never Married 2 X Married 4/4/2 Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Godman Elizabeth Howard Zepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perrrit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 619 Fairway Drive Towson, Md. 21286 Mr. William A. Bach/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 3-31-10 Baltimore, Md. 21. Signature of Ineral Service Licensee 22. Name and Address Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lat only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a 9 🗌 Unknown Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à difficile 2 X No Clost-cidium 1 🗌 Yes 3 Probably 4 Unknown Completed been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 si autopsy performed? Yes No 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Conflying Number Practice on Table 6 and place and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12057 sontour 31. Date filed (Month Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31 per 10 per 3/30/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26<sup>Day</sup> Physician/ MARCH 2010 08:40A M BOLTANSKY NAOMI Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE 3213 WOODVALLEY DRIVE Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral Min. 1 🗆 M 2 і F Months Days Hours 1170371934 MD 218-52-2239 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No PIKESVILLE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21208 3213 WOODVALLEY DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 27 is marked other than "natural", traumatic event, the Medical Exa 3 Nidowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **HOMEMAKER** OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည **ESTHER** HARRY SMITH anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 OLD LYME ROAD, LUTHERVILLE, MD 21093 27 SUSAN BOLTANSKY MANN / DAUGHTER or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State BALTIMORE HEBREW 03/28/2010 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ) Medical ence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No

9 Unknown Day Year Pregnant at time of death is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops perform 1 ☐ Yes 2 ☐ No after death.

Director: After this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence မှ 4 Nursing Home Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of any anomalogo, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 ec. License number th, Day, Year) 29d. Date s ned (Mo 29b. Signat 10 s of person who complete death (Item 23a) (Type, Print) Did. 31. Date filed (Month, Day, 32. Registrar's Signature MAR 30 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM **BROOKS** HAROLD Maga 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Battimore Birthplace (State or Foreign Country) 8. Date of Birth Funeral 6. Sex 1 M M 2 □ F Months Hours 3/97 1923° MD 87 219-18-7803 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21215 6012 HIGHGATE DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 No WHITE If Yes Give "naturaf", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SHOE TOWN STORE MANAGER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ISAACSON DORA **ABRAMOVITZ** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6012 HIGHGATE DRIVE, BALTIMORE, MD MURIEL BROOKS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State OHEB SHALOM MEM PK 3/28/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., I 8900 REISTEPSTOWN ROAD, PIKESVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Mosentosic Physician/ fours disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due (or as a consequence of): Examine ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month 2 No be detached 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No of Vital within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Division Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Dav. Year) 2010

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State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 27, Day 2010 Year 11:00a M Bane Shannon Jesse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Aberdeen <u>3420 Nova Scotia Road</u> 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days May 10, Year 920 1**X** X M 2 □ F Pennsylvania 89 Director 220-10-1969 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21001 USA 3420 Nova Scotia Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 15 Yes 2 9 42 - 194 If Yes, Give 1 9 42 - 194 Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ortant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Exa 3 ₩Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufactoring supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Esther Violet Robinette Shannon Bane and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trat once. <u>Edward N. Bane (son)</u> Carsins Run Rd., Aberdeen, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 4/1/10 Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 21, Signature of Funeral Service Licensee Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metalhehi Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Me Win Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? certificate has 1 ☐ Yes 2 ☐ NO 26. Place of Death (Check only one) Be 25. Was case referred to medical of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 TNo မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of confifier

31. Date filed (Month, Day, Year)

MROWIRE

o wirec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 Abend

Darke

03/29/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Day Physician/  $\mathbf{P}^\mathsf{M}$ Stella Crockett 29 2010 3:20 M. Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel 208 Glen Burnie 403 West Ordnance Road, Apt. Date c. (Month, Da., If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 □ M 2 🗙 F 217-30-2907 74 APR 1935 Maryland Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🔀 No Anne Arundel Glen Burnie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 403 West Ordnance Road, Apt. 208 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. ori 1 Never Married 2 Married \$ 1 🗌 Yes 2 🗶 No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halethorpe, MD 21227 4714 Washington Blvd., Lot 8, Donna M. Trusty, daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Metro Crematory, Inc. 3/30/2101 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Seol, 299 Frederick Road Baltimore, MD ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of). ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami page 2 should be detached for use as the burial-tran. Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 30, 2010 D0062757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229

Registrar DHMH 17 Rev 7/2009

State

Deepak Baskaran, M.D.

31. Date filed (Month)

32. Registrar's Signature

3455 Wilkens Avenue, Suite L 10,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09590 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20ĬÖ' Chong-Po Choe 3:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8639 Wheat Field Way Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Korea April 26, Year 28 1 □ M 2 🖾 F Months Hours Director 216-06-8357 81 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8639 Wheat Field Way 21043 Korea or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 X Married ģ ☐ Yes 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give id Mental Hygiene. marked other than "natural", Korean Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Young C. Hwang Kim Chong Soon .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chol H. Choe (son) 8639 Wheat Field Way Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Crestlawn Memorial Park 3-30-2010 4 Donatien 5 Other (Specify) Marriottsville, Maryland 21. Signa Traffuneral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a, Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each immediate Cause Pinal the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Cardiac Physician/ arrhythmi disease or condition resulting in death) Medical Examiner ial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Stomach the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be en in 24 hours after death. The continuate the continuate Director: After this certificate has been signed by the attending physicial process. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 4 Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \mathbf{Y} \) Residence \( 6 \) Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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☐ Medical Examiner: On the cause (s) a 29a. Certifier within 2 To the I 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -5247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. LISA M. KIM, M.D

Registrar

State

3355

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Ellicott cin

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0959 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:45 AM marcn Medical (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F Days Min. Months Hours Director Residence of Decedent 3a or 28a-f show t be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Street and Number 10g. Citizen of What Country? 23a Funeral must 1. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes 2 No filed within 72 hours after 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural", Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) st, Middle, Maiden Surname, ည Page 1 and 2 should be 19a. Informant's Name/Relationship (Ty ite Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Nu muakter Health tem 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) **Examiner** unknown Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Physician/Medical Examiner of as a consequence of that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ours after death.

Beral Director: After this certificate has been signe filled in by the funeral director, page 2 should be a Physician: The law requires Division of Vital Records, 3 Probably 4 🗆 Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ည Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1. Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Acciden Accident Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie Pollockup Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine D. Pollock, MD 2019 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

10-02389

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 09592 State of Maryland / Department of Health and Mental Hygiene Lagenia Clanton 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Clanton Lugenia 2017 hrs March 25, 2010 Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 601 Wyanoke Avenue Apt 125 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director 238–64–8818 <del>68</del> 04/21/1942 Country) NC 1 M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County Baltimore 1 X Yes 2 No , or items 23a or 28a-f show r must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 601 Wyanoke Avenue, Apt. 125 21218 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2X No Yes Black f Yes, Give Year 1 Yes 2 X No specify: Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pleted Elementary/Secondary (0-12) College (1-4 or 5+) Sales 21215-0036 Clerk 12 Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julius E. Clanton Julius James Allen Lucille Harris is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ₩ .: 194 Chester Street, New London, CT 06320 James E. Clanton / Son If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Final Journey Crem. 1 Burial 2 X Cremation 3 Removal from State 3/30/2010 Woodbine, MD Donation 5 Other Specify: 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licen Dowota Marshall 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ∕Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last by the attending physician and ached for use as the burial - transi Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X AMENDED UNPENDED as noted per ME , 7, 17, pe rFH G902 4/12/10 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed in funeral director, page 2 should be deta Š 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other: Nursing Home 5 Residence 6 🗹 Other: Scene 2 ER/Outpatient 3 DOA Inpatient 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Division 1 Yes 2 No death. Director: d in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 24 hours after Could not be Suicide or Town, State) Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. March 26, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ M93 :50A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood . Social Security Number 7. Age (In yrs. last birthday) 91 Yrs. 8. Date of Birth
December 18, 1918 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 135-01-2044 1 □ M 2 💯 New York Director Jsual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maryland Anne Arundel Harwood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 20776 United States 3675 Solomon's Island Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical gonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home / Real Estate Homemaker / Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Genevieve Harrigan Charles Elmer White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2430 Maytime Drive, Gambrills, Maryland 21054 Kathleen A. Busch / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 29, cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Fun Service Licensee 22. Name and Address of Facility.
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caussion each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse mence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and -transit that initiated events resulting in death) Last Due to (or as a consequence of) as the burial attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months? Por Month Day Year Pregnant at time of death the detached 9 Unknown P.O. n signed by t ald be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b brillation Division of Vital Records, Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen Sema 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? perform certificate IKOKE 1 🗌 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **V**No Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 A Other (Specify) Hospice 24 hours after death. Funeral Director, After this filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending iniury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. **Tpleted** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one 29b. Signature and title of certif 29d. Date signed (Month, Pay, Year) who completed cause of death (Item 23a) (Type, Print Jame and address of filed (Month, State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		Decedent's Name (First, Middle, Last)		^			2. Date of Death	1	3. Time of Death	
Physic /Medi		Heredo		Ce	reade	C	March	Day Year	12:28 A M	
Exami		4a. Facility Name (If not institution, give s	· ·		4b. City, Town, or		h	4c. County of Dea		
Andrew Comment		The Johns Hopkins Ho  5. Social Security Number 6. Sex		ast hirthday)	Baltimore	City  If Under 24 Hrs	8. Date of Birth	N/A		
Funeral Director			M 2 □ F 60		Months Days	Hours Min.	(Month, Day, FEB. 2	Year) 3,1950 PI	thplace (State or Foreign untry) HILIPPINES	
σ		Usual Residence of Decedent								
anylar shov d at	5	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No	
the M 28a-f otifie	Director	MD N/A		BALI	IMORE 10f. Zip-Code		10	g. Citizen of What Co		
3a or	Ö	116 N. MILTON	AVENUE		212	2.4		U.S.A		
death	Funeral		12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H. f Yes, specify Cuba		Specify Yes or No-	14. Race - Ame	rican Indian,	
36 after or its	by Fu	1 Never Married 2X Married	1 ☐ Yes 2 XNo If Yes, Give		i res, specily Cuba I □ Yes 2 X No	Specify:	to mean, etc.)	Black, Whit		
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in 72 In 72	plet	(Specify only highest grade		(Give	kind of work done o	during most of wo	orking	TOD. Tana of Basinose	, incoding	
21215-0036 od within 72 hours aft giene. er than "natural", or the Medical Examir	Completed	Elementary/Secondary (0-12)	College (1-4-01-5+)	TEC	HNICIAN			MEDICA	L	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Lest)					me (First, Middle, M	•		
faryla 2 should to and Ment is marked aumatic e	မ	ANASTACIO	CERCADO	don Marilia	A d d (Ot			City or Town, State, 2	7i- O- d-)	
<b>≥</b> ₽ € ▷ ₹		19a. Informant's Name/Relationship (Type) FLORINIA CERCAD			,			CIMORE, ME		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	i	<del></del>	20c. Location - City or		
Baltimore, permit. Pages 1a Department of Hee Important: If item any injury or othe once.		1 ☐ Burial 2 XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	cilioval iloili otate		natory or other plac CREMATO	-	27/10 E	BALTIMORE	, MARYLAND	
Balti permit, Departm Importa any inju		21. Signature of Fune Service Licenses		/ 22				NERAL HO		
<b>©</b> 88 5 5 6		(all)	South		901 EAS	TERN A	VENUE, BA	LTIMORE,	MD 21231	
		23a. Part 1. Enter the disease, or complications, or heart failure. List only one	cations that caused the death e cause on each line.	. Do not ente	er the mode of dyin	ig, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death	
▶ Physician		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):								
Examiner			C C C C	· li	1170	Moon	50			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ience of							
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760, xite be executed hysician and the burial-transit	ical E	resulting in death) Last	Due to (or as a consequ	ience oi):						
68760, rtificate be e on physician e as the buri	edic	d								
Box 6 eath certifi attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnat					23d. Date of de	livery	
P.O. Box (hat the death cert do by the attending detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)	/		Month	Day Year	
P.O.	Phy	9 Unknown		dalaa la daa u		on in Book I	OO - Distant		4	
I Records, P.O. Box 68:  The law requires that the death certificat tte has been signed by the attending ph page 2 should be detached for use as th	by	Part ii. Other significant conditions contributing to death out not resulting in the underlying cause given in Part i.						acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown		
cords,  v requires t been signe should be	etec						24a. Was an		utopsy findings available	
Rec	Completed						autopsy perform	prior to death?	completion of cause of	
Vital Records, sician: The law requires the certificate has been signed irector, page 2 should be a	Be Co	25. Was case referred to medical	26. Place of Death				1 □ Yes 2 ath (Check only one		2 🗆 No	
of Vi Physicia this cert ral direct	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 I	Other:			Home 5 ☐ Residence 6 ☐ Other (Specify)			
IVISION Of VITA Attending Physician: sr death. ector: After this certifics by the funeral director,		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	28c. Injury at Work? 28d. Describe ho			w injury occurred	
Division  or Attending after death. Director: After	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At hor	me farm etre		Yes 2 No	29f Location (Str	eet and Number or R	ural Poute Number	
Div Al	ertif	4 Homicide determined	building, etc. (Specify)	)	ot, lactory, ciliac		City or Town,		arai House Nambel,	
Hospital 24 hours a Funeral I	0	29a. Certifier 1 Certifying Phys	ilclan: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the tin	ne, date and plac	e, and due to the ca	ause(s) and manner a	s stated.	
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Mont		
<b>₽</b> ∯ <b>₽</b> ⊗		(2) man	_mp		D S	5-000	.   29	la. ~ la d	10,7010	
		30. Name and address of person who co		23a) (Type.	Print)	5 000		WICH C	0,000	
		Brian M. Thomas	, MD		ŕ	600	North Wolf	e St, Baltim	ore, MD, 21287	
Sta Regist		31. Date filed (Month, Day, Yeer)  NAR 3 0 201	32. Fegistrar's Signatu	1. A.	arke					

DHMH 17 Rev 1/2001

		A	Amend #1 per MD g901	oe or Print in B tate of Maryland	lack In	idelible Ink	. Ensure Al	l Copies	s Are	Legible.	
			1 - State Registrar	iato or maryiane		rtificate of		iornai i i	Reg. No	0010	09595
	Physici	an	1. Decedent's Name (First, Middle, Last)	1				2. Date of Do Month	eath Da	ay Year	3. Time of Death
week.	/Media	al	4a. Facility Name (If not institution, give stre		l Ray	Carter	or Location of Death	Month 3		C 2016 County of Deat	
1	Examir	ier	Mercy Medical (	Center		Beltimer	MID			Beltimon	/./
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 9 / 18 /	irth av, Year,	9. Birt	thplace (State or Foreign ountry) CAROLINA
	Director		Usual Residence of Decedent					3/10/	190	0 14.	
	show show	or	10a. State 10b. County		Town or Lo						10d. Inside City Limits  1X Yes 2 □ No
	r 28a-i notifi	irect	MD N/A  10e. Street and Number	L	3AT.T.T	MORE 10f. Zip Code			10g. Ci	itizen of What Co	untry?
	ath with	ralD	106 S. PATTERSON	PARK AVEN			231			U.S.A.	•
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 【X Married	Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 <b>X</b> No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☐ No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White Specify: AMI	e. etc.
15-0	"natu	letec	15. Decedent's Education (Specify only highest grade co	on mpleted)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of working	ng	16b. k	Kind of Business/	Industry
212	d withir giene. er than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		JCK DRIV	•		T.	RANSPO	RTATION
pu	d d d d	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle	e, Maidei	n Surname)	
Maryland	should nd Mer marke matic	2	JOHN DAVID CAF  19a. Informant's Name/Relationship (Type.	RTER	19b Maili	ing Address (Street	DOLOR and Number or Rura		ENN ber. City		7in Code)
	말 높 <b>C :</b>		ANNA CARTER/ WIFE	·			L AVE.,B		-		21222
altimore,	ges 1 and it of Heali if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Remo			osition (Name of matory or other pla		ate		ocation - City or	
Itim	permit. Pages ' Department of I Important: If ite any Injury or of		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fureervice Licensee	BAY			ORY 3/13				, MARYLAND
Ba	lmp per any		- Augo	tend		LILLY & 1901 EA	ess of Facility ZEILER STERN AV	INC. ENUE,	FUN: BAL	ERAL HOTIMORE	OME MD 21231
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one c Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ons that caused the death auss on each line.  Due to (or as a consequence to to to to to to as a consequence to to to as a consequence to to to to to as a consequence to to to to as a consequence to to to to as a consequence to to to to to to as a consequence to	Cute ence of):	1	ng, such as cardiac c	1	1		Approximate Interval Between Onset and Death
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Examin	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
P.O. Box 6	at the death certific by the attending p tached for use as i	Physician/Medical	in the past 12 months?	If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□ Ectopic pregnand □ Other (specify) _	су			23d. Date of del Month	livery Day Year
ds, F	signed det	호	Part II. Other significant conditions contrib	uting to death but not resul	ting in the ι	underlying cause giv	ven in Part I.				the cause of death?
Records,	law requir as been s 2 should	Completed						24a. Was		24b. Were au	utopsy findings available
E Re	ician: The lav certificate has ector, page 2	mo <sub>C</sub>						auto perf 1 ☐ Yes	opsy formed? 2 □ N	death?	completion of cause of
Vital	sician: certific rector,	æ	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Hosp	nital:		ont 3 🗆 DOA Ott	26. Place of Death	,			
	g Phys ter this seral dii	n: To	27. Mannes of Death	1 Inpatient 2 E 28a. Date of Injury (Month, Day, Year)	R/Outpatie 28b. Time o Injury	III 3 DOA	ry at	me 5∐ Res 28d. Describe		6 ☐ Other (Spe ury occurred	cify)
Division	Attending F r death. ector: After by the funer	Certification: To	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At hor	ne, farm, st	M 1 □	Yes 2□No	28f. Location	(Street a	and Number or Ri	ural Route Number,
	Hospital or , , , , , , , , , , , , , , , , , ,	Certi	4   Hornicide	building, etc. (Specify,				City or To			
7		Medical		an: To the best of my know On the basis of examinati and manner stated.							
σ· _	To the within 2 To the comple	Me	29b. Signature and title of certifier	111		29c. Licens			29d. D	ate signed (Mont	h, Day, Year)
			· Charlena W		00-) /T	P24	448			1011	
_			30. Name and addless of person who comp	eled cause of death (Item	30 (Type,	1 51 1	Pan/ Plac	r B.	alti	mere.	mo
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Jre A. A	harkel		,		- *	

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 09596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 1 55 PM Virginia Lee Cernik MARCH 23 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BEL AIR CHESAPEAKE MEDICAL CENTER UPPER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
72 Yrs. Date of Birth (Month, Day, Year) Oct 13, 9. Birthplace (State or Foreign 5. Social Security Number Days Hours Months 1 □ M 2 K F Maryland 1937 219-26-4458 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 United States 1014 Prospect Mill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 KNo Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1:14or 5+) Elementary/Secondary (0-12) Technology Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Naomi Wingate Leo Frederick Febrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Georgia Tracey /Sister 1014 Prospect Mill Rd. Bel Air, MD 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar 29 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nacomenhadics of Facility Funeral Alternatives Kebocca Ancheemon 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMDSTAGE CHRONIL OBSTRUCTIVE PULMONARY DISEASE YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Sup to for as a pointed uanno off day, leading to himedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1' ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

P.O. Records, of Vital Division

law requires that the death certificate be executed sician and burial-trans the attending physician the been signed by has or Attending Physician: The certificate this after death filled in by hours a 24 hours a Funeral I Hospital completely To the I

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Practical Eventual transition and once.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland

,088008

25. Was case referred to medical 27. Manner of Death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a, Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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MARCH

23:

2010

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 UPPER PRIVE, BEL AIR, MD OFOSU, IND CHESAPEAKE 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature Denve S. Jak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** A UD 2010 Prince George IVEY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 27, 1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 2 F Months Days Hours Min. 76 217-32-4814 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at Y□Yes 2□No MD Prince George Cheverly Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō 20785 2333 Belleview Avenue USA Hygiene. other than "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Modical Examiner must, once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces □Yes 2 No Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No SpecifyBlack Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James L. Cager Fannie Mae Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Simmons/Niece 2333 Belleview Ave. Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Cre 3/26/10 Marriottsville, MD 22. Name and Address of Facility of Funeral Service License 2700 Edmondson Ave. Balto., and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician ; the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) P.0. a I I Inknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 300 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 | Yes 2 | No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural e Hospital or א. 24 hours after death. ייי איז Director: איז Director: איז יייי 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Ac 8 per FH G902 4/1/101 dk

Amend State of Maryland / Department of Health and Mental Hygiene For State Registrar Q Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Physician/ Dawkins 1236 PM John Henry Ma 7010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Howard County General Columbia Howard 1963 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Sex 1 M 2 F Funeral (Month, Day, Hours Min. Days Virginia <u>~2010</u> Jan. 47 Yrs. 231-06-2579 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗆 Yes 🚈 No MD Carroll Eldersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 5978 Cecil Way 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Specify: Black 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12th Grade (0-12) College (1-4 or 5+) Self-Employed Entrepreneur Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Luwatha Ann Oulds John Henry Dawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila Houston/Sister 5978 Cecil Way Eldersburg, MD 21784 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Green Mount Cem. Baltimore, MD 3/31/2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore, MD 21215 Varie 23a. Pp. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Polymicrobia Pnysician. disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the af d be detached fo 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: death? 2 1 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 Yes 2 No 5 Pending M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00066 SIT Mar 29

State Registrar

DHMH 17 Rev 7/2009

55 Codor Lane Co Lubra MD 21045

MA

MD 32 Registrar's Signature

01

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March Eugene 7:25 2010 Medical Davis 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Baltimore Richey N/A Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🕅 M 2 🗆 F Months Days Hours (Month Day, Year) 3V 8 1944 218-42-5578 Director 65 May Usual Residence of Decedent if leads and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show
other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2234 Linden Avenue 1st Floor 21217 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Black 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Forklift Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Davis Iseline unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanna Cornish/ Daughter 2234 Linden Avenue 1st Floor, Baltimore, Maryland 21217 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Marchat 30. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 2010 Metro Crematory Baltimore, Maryland Tnc 22. Name and Address of Facility Cremation Society of Maryland, 99 Frederick Road, <u>Baltimore</u>, Maryland 21228 Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SASTRIC M00745 Medical Due to (or as a consequence of): Examiner ERYRARE Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Duc to for as a consequence of: the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 β for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ∐ Pregnant 9 ∏ Unknown been signed by the sahould be detached it 1 ☐ Yes ≥ ☐ 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed' Hospital or Attending Physician: The After this certificate 2 🗆 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation within 24 hours after det To the Funeral Directol completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 100 14221 3.29.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLun 223 BALT was 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

C/1020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 Year 3 15 AM Albert W. Deisroth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rosedale Baltimore FRANKLIN Square Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) May 4,1940 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 D F 215-40-8897 69 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Sandhill Road 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify.White "natural", 3 Widowed 4 Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hour partment of Health and Mental Hyglene. Sortant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Worthington Steel <u>12th</u> Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert W. Deisroth Frances M. Humphreys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Helton /step-son Sandhill Road Balto. MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Holly Hill Cemetery 3/27/10 4 Donation 5 Other (Specify) Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Home of Essex 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List body one cause on each life. Interval Between Immediate Cause (Final Onset and Death Diabetes Physician disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No q Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ils certificate has director, page 2 performed 2 🗆 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No I Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ddress of person who completed cause of death (Item 23a) (Type, Print) DR Rachel 4000 FRANKLIN mallalieu Square DR Balto md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 3 0 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4a State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Wendler Dorothy Davis March 26, 1:10a M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Walton Road Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/18/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Min. Months Hours 89 Days 1 □ M 2 □ XF 198-01-9619 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Bethesda Montgomery Yes 2 □ No MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 5910 <del>5901</del> Walton Road 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 🏖 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mann Trene Edwin Wendler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5901 Walton Rd., Bethesda, MD 20817 Richard Davis / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crem. 3/29/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshal 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEAR Immediate Cause (Final CARDIOMYOPATHY disease or condition resulting in death) Due to (or as a consequence of): CORONARY ISCHEMIC HART DISEASE UNKN. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). CHRONIC KIDNEY DISEASE Due to (or as a consequence of): PERIPHERAL VASCULAR DISEASE IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ZNo Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Dunknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Jnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

and burial-trar attending physician for use as the buria the detached à signed I page 2 should has certificate e Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica director, the filled in by

Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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filed within 72 hours after of Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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traumatic event, the Medical Examiner must be notified at

Physician/Medical 2 Completed Be ٩ Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

within 24 6 V

29b. Signature and title of certifier

6 Could not be determined

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Yuri Deychak, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature back MAR 30 2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amedn 19b, per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 **Physician** MARCH 12:25A DIENER SYLVIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/25/1911 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Min 1 □ M 2 🗓 F MD 98 Director 212-34-6205 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffied at once. 1 ☐ Yes 2 X No Director BALTIMORE PIKESVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8911 REISTERSTOWN ROAD 21208 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ 3 Nidowed 4 □ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HEISTER PLOTKIN FANNIE PHILLIP ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 2120 & Circle
10 GLENCLIFFE ROAD, BALTIMORE, MD 21022 19a. Informant's Name/Relationship (Type. Print) RONALD DIENER / SON 20b. Place of Disposition (Name of cametery crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/29/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Thrombosis Physician /Medical Due to (or as a consequence of) Examiner ARDIOVA SCULAR ATHEROSCLERUTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No : After this certifications : After this certification : To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Spe Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0043375 2010 03 28 UL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAKEN W. LIERLIETT 2835 STITH AVE, ISALT MORE MD 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 **>** Registrar

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #4a&b 2&10e Per Phy&FH G902 4/08/2010 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03-28-2010 3. Time of Death DCON Physician/ NIHI Medical 4a. Facility Name (if not institution, give street and number, **Mandrin Hospice House** 4b. City, Town, or Location of Death **Harwood Examiner** 4c. County of Death Mandarin Chesapeake Anne Arundel 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🗆 M 2 🗷 F Months Hours Min. (Month, Day, Year) 136-26-4710 74 Director May 16. 1935 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State South 10c, City, Town or Location 10d. Inside City Limits Director Carolina 1 ☐ Yes 2 🙀 No Clover York 10e. Street and Himber ler 10f. Zip Code 10g. Citizen of What Country? Funeral 1 King Haiger Chase 29710 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 KNo Black, White, etc 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Covell Newbury Ann Ready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Edson, Daughter Tarragon Lane Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/29/10 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland Inc. Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami g physician and sthe burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 ... No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} 2- No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one Signature and title of certifie cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY ANNAPOLIS MOLIYU 31. Date filed (Month, Day, Year) 32. State Registrar

DHMH 17 Rev 7/2009

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		-	e of Death	Reg.	No. 2010 09604				
Physician/		Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death				
ledical Examir	ner		Epling	Month Di March 25, 20	10 2344 hrs				
		4a. Facility Name (if not institution, give street and number)  Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	1	Anne Arundel				
Funeral		Social Security Number		8. Date of Birth(	MM/DD/YYYY) 9. Birthplace (State or				
Director		214-88-7863 <sub>1 M 2 F</sub> 46	Months Days Hours Min	08/26/1	963 Foreign MD				
	ŀ	Usual Residence of Decedent							
* any		10a. State 10b. County 10c. City, Town or MD Prince George's	Location Hyattsville		10d. Inside City Limits 1 X Yes 2 No				
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th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 7110 Adelphi Road	10f. Zip Code 20782	10g.	Citizen of What Country? USA				
ith the			3. Was Decedent of Hispanic Origin? ( S	pecify Yes or No.	14. Race - American Indian, Black,				
eath w items	Funeral	1 XX Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		White, etc.				
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify: White				
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36 in 72 han "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Carpenter		Construction				
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	B	Roy Lee Epling	Pat	ricia Bu	uchon				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relationship (Type, Print)  Roy Lee Epling / Father 2	Mailing Address (Street and Number or 826 Kosuth Road, Pa	Rural Route Numbe	r, City or Town, State, Zip Code)				
and 2 sho ealth and cen 27 is traumati	-		Disposition (Name of cemetery,		Oc. Location - City or Town, State				
Baltimore, permit. Pages I an Department of He Important: If ite		Final	y or other place) Journey Crem. 3/	31/2010	Woodbine, MD				
Itim iit. Pa artimen ortani		4 Donation 5 Other Specify:  21. Signature of Funeral Service Sicensee Dorota Marshall			·				
De president		Doube W Marshall	22. Name and Address of Facility Maryland Cremat PO Box 1413, Ba	ion Servi Itimore,	ices MD 21203				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	, shock, or heart Approximate Interval Between Onset and				
Examiner		Immediate Cause (Final disease a. Atherosclerotic	cardiovascular dise	ase	Death				
		or condition resulting in death)  Due to (or as a consequence of):							
	Je.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):							
	Examiner	eause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Use to (or as a consequence of):							
executed ian and ial - transit		d							
be exe	dic	X AMENDED #1 as noted 23a,27,permE	1 per ME g903 5/10/ , g902 4/6/10 TT	10 TT					
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn		23d. Date of delivery  Month Day Year				
x 68 h certi tendin	ciai	past 12 months?  4 Pregnant at time of death 5 Other (Specify)							
Bo ne dear the at	hys	1 Yes 2 No 9 Unknown 9 Unknown	n Paris	loga Didasha	cco use contribute to the cause of death?				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ğ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part i.		2 No 3 Probably 4 Unknown				
ords, w require us been sig	eted			24a. Was an	24b. Were autopsy findings available				
COF e law r e has b	ompleted			autopsy performe					
Vital Rec ysician: The his certificate director, page	င္ပ	25. Was case referred to medical	26.Place of Death (Check		No 1 Yes 2 No				
Vita hysicia this cer	o Be	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Out	patient 3 DOA Other Nursi	ng Home 5 Re	esidence 6 Other:				
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been so led in by the funeral director, page 2 should I	ü	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Ti	me of Injury 28c. Injury at Work?	28d, Describe hov	v injury occurred				
Sion Attend r death. ector: by the f	atic	2 Accident Investigation	1 Yes 2 No		D 18 N 1 0				
Divis pital or A ours after leral Dire filled in b	ertification:	Suicide Could not be determined (Specific)	n, street, factory, office building, etc.	or Town, Stat	eet and Number or Rural Route Number, City e)				
Lospit 4 hour funers	ပ	4 Homicide  29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, and	d due to the cause(s	s) and manner as stated.				
Division To the Hospital or Attention 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner:On the basis of examination and/or invariant and manner stated.	restigation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s)				
E 3 E 3	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)				
1		N-M-	O.C.M.E.		March 26, 2010				
Karb,		Name and address of person who completed cause of death (Item 23a)     Donna M. Vincenti, MD	111 Penn Street, Baltimore, N	MD 21201					
1	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u> </u>						
Regist		MAD O GOOD ALL ALL	ks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marian H. Flynn : 25 A M 2010 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1605 Wa<u>ldon Court</u> Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Yea Aug. 15 7. Age (In yrs. last birthday If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours 1 M 2 DX 218-12-0294 85 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD Baltimore Parkville 1 🗌 Yes 2 🏻 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1605 Waldon Court 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc ö 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. þ Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker 12th own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o Department of Health and Ment. Important: If item 27 is marked any injury or other. Emil Hladik Marie Dvorak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Gaines /daughter 4404 Fieldgreen Road Nottingham MD 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Gardens of Faith 4/1/10 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ Careinomo - orman disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the bunial-transit and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnagt 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months Por Month Year Day the 9 Unknown P.O. ģ Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Division of Vital Records, 1 🗌 Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify 27. Manne of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death the Suicide 6 Could not be

State Registrar

completed filled in by

within 2

Medical

4 Homicide

29a. Certifier (Ched

29b. Signat

only

determined

e and title of certifier

filed (Month, Day, Year)
MAR 3 0 2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 30th 2010

L'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0 45390

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JOHN KIMBLE FASSEL 20-30 PM 03 26 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 Director 87 Maryland 216-16-0720 1923 14. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 28a-f Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 1227 St. Francis Road Funeral 21014 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 21 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Utilities Construction Project Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kimbell Fassel Sr. Alice (unk) Shue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1227 St. Francis Road, Bel Air, Maryland 21014 Gertrude Fassell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 4-3-10 Baltimore, Maryland Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signatur any ir 50 W. Broadway, Bel Air, Maryland 21014 Pairt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYO CARDIAL INFARCTION HOURS ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No signed by the 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Moovy 34427 3/24/10 Division of Vital Records, \$ PNEUMONIA ASPIRATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No has page 2 autopsy performed? certificate 2 110 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred L. ne Hospital or Att. 24 hours after death. veral Director: Aft. 'ed in by the funer. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

To the I within 2

State Registrar 29b. Signature and title of certifier

FRANZ VELLA-CAMILLERI

M.D. 5 MIDCREST CV. BALTIMORE

29c. License number

DO 21207

29d. Date signed (Month, Day, Year)

03/27/2010

MD 21286

and manner stated.

32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTENDING PHYSICIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 26, Day 2010 Year Physician/ Douglas Newton Forman 10:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5404 Wilson Lane Montgomery Bethesda 5. Social Security Number 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) OH Months Days Hours 296-01-0831 0172971918 92 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5404 Wilson Lane 20814 USA death 12. Was Decedent Ever in U.S. Armed Forces? 14.5 Yes 2 □ No If Yes, Give 1944-1945 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or à 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Newton Forman Amy Gilson March 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5404\ Wilson\ Ln.\ Bethesda,\ MD\ 20814$ Ruth N. Forman, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory njury or 1 Burial 2XXCremation 3 Removal from State 3/27/2010 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature eral Service Conse 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bronchiectasis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or linjury Due to (or as a consequence of): Exam that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as IE EEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 months? Month Day Yea Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? this certificate Yes 2 No Physician: director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural To the Hospital or Attending 5  $\square$  Pending work? injury within 24 hours after death To the Funeral Director: A 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OHMH 17 Fev 7/2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 3 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ava Kaufman, MD 8218 Wisconsin Ave. Bethesda, MD 20814

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D26259

29c. License number

29d. Date signed (Month, Day, Year)

3/26/2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2010 0225 AM **Physician** Ann Marie Finnel MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMO RE AGNES HOSP ITAL n/a Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/12/1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Yrs 75 219-30-5516 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 Beaumont Avenue 21228 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify. ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Tech. Support Government Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Albert Pohlman Florence Scharer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joanna M. Rutkowski / Daughter 459 Whitfield Road, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/30/2010 Woodlawn Cemetery Woodlawn, Maryland 4☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 2 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death DAYS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMINIA Physician disease or condition resulting in death) /Medical OBSTRUCTION Examiner DAYS-WEEKS BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś Ş CARCINOTHA 1 Yes 2 No 3 Probably 4 Unknown Record Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No HYPOTHYROLDISM 2 No Vital 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation Division 1 □ Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P21798 MARCH 27 2010 900 CATON AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHAVAMDEEP BALTIMORE, MD. 21229 31. Date filed (Month, Day, Year) egistrar's Signature parker State Registrar

MARIE

ANN

TINNEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No./ Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 25 Day Shirley Audrey Folks 3:30 2010 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6304 Merle Way Elkridae Howard Social Security Number 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Min. 1 □ M 2 🗓 F (Month, Day, Year) 2/13/1935 Hours Maryland Director 212-32-6353 74 Usual Residence of Decedent show with the Maryland or than "natural", or items 23a or 28a-f sho the Medic I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Elkridge 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6304 Merle Way 21075 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Store Clerk Retail Food Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fred Denner Anna Rose Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Feehley (Daughter) 6304 Merle Way, Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■Burial 2 ☐ Cremation 3 ☐ Removal from State 03/30/2010 4 Donation 5 D Other (Specify) Baltimore National Baltimore, Maryland Sign were of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final ATHEROSCLERUTIC Onset and Death Physician CARDIOVASCULALL disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Hees

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ROLLING

29c. License number

DOD 5845 +

LOAD, BATTMARE, MARYLAND 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Leroy Randolph Glee 2010 7:50pM March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours Min Sep. 3. 1961 1 X M 2 D F 48 Maryland Director 218-74-3768 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Maryland N/ABaltimore 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1548 Pentwood Road 21239 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 X Married Yes 2 No þ Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify Black Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Project Release Loyola University Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Wyatt Glee Minnie McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 548 Pentwood Road, Baltimore Shelia Glee/ Wife Maryland 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 29 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 <u>Frederick Road, Baltimore,</u> Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ a MONSWall disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Securification of the conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Due to (or as a consequence of): resulting in death) Last physician Physician/Medical as the attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ completed filled in by the funeral director, page 2 should be Division of Vital Records, The law requires 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 2 No Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) RNY 3219010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 95 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, 2010 Physician/ Month Joseph M. Genco March 12:45P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. Manor Care
5. Social Security Number Rossville Rosedale 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, October
 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Maryland 10,1921 **Director** 88 216-16-3570 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Balto. Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9605 Heathcliffe Drive 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 4 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates Specify 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Own Business Shoe Repair Be per it. Page 1 and 2 should ·e filed De; artment of Health and Mental Hy Important: If item 27 is mar ed oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Petro Genco Margaret Maltese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9605 Heathcliffe Dr. Rosedale, Md. 21237 Nellie Genco Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 3-29-2010 Gardens of Faith Balto, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Schimunek Funeral Home 22. Name and Address of Facility telaure 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
5 Other (coordid) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed after death.

Director: After this certificate Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 1 🗌 Yes Certificate: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Month, Day, Year) MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wood

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month David K. Galloway 4116 A 3 26 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BalTIMORE FRANKLIN Square Hospital Rosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 April 30, 1951 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 1 XM 2□ F 58 075-40-0540 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2√2 No MD Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 70 Transverse Avenue 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Auto Parts Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Man 18. Mother's Name (First, Middle, Maiden Surname) 12th 17. Father's Name (First, Middle, Last) Kenneth Galloway Lillian Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dale Snyder 2023 Lonfview Avenue Baltimore MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 291 10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD atte Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arresT Cardiac disease or condition resulting in death) Due to (or as a consequence of): Due to lo as a consequence of: arrest C.O.P. D Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? peripheral 1 Pres 2 No 3 Probably 4 Unknown

**Physician** /Medical **Examiner** 

attending physician and for use as the burial-tran

signed by ti d be detach€

After this

within 24 hours after death To the Funeral Director:

filled in by

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Completed

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Certification: To

ical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examinar must be political at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event, the Magnetic pages.

death with the Maryland

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Baltimore, Maryland 21215-0036

Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

vascular disease pertension

24a. Was an 2 **116** 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

MD DO067517

3/26/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAANKLIN Square DR Balto md 21237 RICA Bonomo 9000

State Registrar 31. Date filed (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Goodman 2:50 A M 2010 Medical 4a. Fæility Name (if not institution, dive street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltimore easons 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🗆 M 2 🜠 F Director 28a-f show 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 SalYes 2 ☐ No MDHimore 10e. Street and Numb 10g. Citizen of What Country? Funeral 21207 toni N9 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Blac permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Expone. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during He: DO NO use retired) College (1-4 or 5+) onday (0-12) Be မ Hmos ones Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural ronina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) oudor 21. Signature of Fune al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Laryngeal Carcinoma Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 🗌 Yes 2 No ျ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manger of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MS RajupanseMD 00057465 3125/10 2835 Smith Av. 5-203, Bultimore, MO. 21209 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rajapakse, M.D.

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State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Marc D: XI 4a. Facility Name (If not institution, give street and number) 20 2010 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner 1. tomore NOVY hues 7 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Min. 1 □ M 2 🕱 F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director unn Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 14. Race Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ò 3 Widowed 4 Divorced "natural" ac Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic event, the Maone. Elementary/Secondary (0-12) College (1-4or 5+) 0 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ laene DYCE 19a. Info mt's Name/Relationship (Type. Print) mortier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/22 & ARTA 2 01 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation ✓5☐Other (Specify) 21. Sign ture / Funs al Service Licensei 22. Name and Address of Facility

OSEPH L. RUSS FW

2222 W. North Ave. Funeral Home, P.A. ve. Balto, Md. 21216 Talel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Just Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi 5 Due to (or as a consequence of) and physician sthe burial Box 68760. Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for Month Day Year 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Ves 2 2 No has Iron overioad 1 □Yes 1 ☐ Yes 2 ☐No Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No 1. Inpatient 4 
Nursing Home 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) of this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 24 hours after death. 5 Pending investigation 1 atural 1 ☐ Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) U0056630 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of no

State Registrar

DHMH 17 Rev 1/2001

Lee-Garale

31. Date filed (Month, Day Year) 32. Registrar's Signature

DId

540

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Mary E. Gibson 20ปื0 7:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove Carroll House Westminster Social Security Number 6. Sex 8. Date of Birth
(Month, Day, Year)
11-2-1927 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🏝 I Hours Min. 82 Director 220-24-4363 Usual Residence of Decedent shov 10a. State 10b. County ms 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 5561 Sykesville Rd. USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife 12 Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Volk Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 168 W. Main St., Westminster, MD 21157 William A. Gibson-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Westminster Cem. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 3-30-2010 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Thomas ? 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line? Approximate Interval Between erval Between Iset and Death ROLL Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for signed by the attending physician and be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: use ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 🗌 Yes No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should can insufficery. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manna of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Natural work' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of rson who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State MAR 30

DHMH 17 Hey 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27 ay Griffith March 2010<sup>a</sup> Ann 7:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8374 Elvaton Road Millersville Anne Arundel 8. Date of Birth (Month, Pay, Year) Jan. 13, 1960 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours 214-78-3187 50 MD **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🛛 No MD Anne Arundel Millersville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8374 Elvaton Road U.S.A. 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Mortgage Title Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be flled and Mental H is marked of ည Frank E. Sellers Diane E. Schaeffer other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health at.
Important: If item 27 is any injury or other Mr Andrew Griffith /Son 8374 Elvaton Road Millersville MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 29 cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crematory 2010 Glen Burnie, MD 4 Donation 5 Donation 5 Donation 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signatum. MD 21061 Services PA 1 2nd Ave. SW Glen Burnie, 01220 Put 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Se uentiall, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence ot): Exami certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2X No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5 Residence 6  $\square$  Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည this 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funera Certificate: Hospital or Attending Natural Accident 5 Pending work death. 1 Tyes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined after within 24 hours a To the Funeral L Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

3

Name and address of person who completed c

of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

hway Sw Olen Byrme MD21061

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

### State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** Monroe Griffith 24 2010 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE A PUNISE 1 BURNIE BALTIMORE WACHTINGTON MEDILAR CENTER 8. Date of Birth (Month, Day, Oct. 15, Social Security Number **Funeral** Hours 1 ☑ M 2 ☐ F Months Days 214-14-3846 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 1 ☐ Yes 2 No Director Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 209 McKinsey Road 21146 "natural", or items 23a U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? I X Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: If Yes, Give Year or Dates: Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) RIFFITH and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Staff Manager of Purchasing C & P Telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Monroe Griffith Louise Edna Meyers ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Betty Mae Watts/Daughter 209 McKinsey Road Severna Park MD 21146 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of Important: If it and any injury or o 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 2010 22. Name and Address of Facility Singleton Funeral & Crmeation 21. Signature of Funeral Service Licenses Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MO135 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIC **Physician** /Medical Due to (or as a consequence of): Examiner OBG PUTINE TULMONEARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No ed by the Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t irector, page 2 s autopsy performe 2.200 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 1 Matural 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) D45149 Glen Barne mi) npleted cause of death (Item 23a) (Type, Pr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar Date filed (Month, D

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and M  1 - State Registrar  Certificate of Death	_		
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3 Jime of Death
	Physicia /Medic		IDA GREEN FELD	March	28, Zer	420 AM
- w. )	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death BALTIMOR	E
	Funeral		SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs.	8. Date of Birth	a Rirthr	lace (State or Foreign
ı	Director		212-01-5097 1 M 21X F 93 Yrs. Months Days Hours Min.	03/10/1	917 Couir	MD MD
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		1	0d. Inside City Limits
	a-f sh	ctor	MD N/A BALTIMORE			1∭XYes 2□No
	or 28	Dire	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	•
	eath w	Funeral Director	6503 PARK HEIGHTS AVENUE, #4M 21215  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	USA an Indian.
9	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, I in Medical Evanding in it ust be notified at	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
21215-0036	ural", c	Completed by	3 AWidowed 4 □ Divorced Year or Dates:		Specify: WHIT	
-15	in 72 h	plete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		6b. Kind of Business/Ind	dustry
212	d with /giene er tha	Com	Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER		OWN HOM	E
Maryland	s d al s	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  COLLAMES  DESCRIP	e (First, Middle, Ma		STEIN
ir Ži	should nd Me marke matic	2	JOSEPH  SCHAMES  BESSIE  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rur	al Route Number,		
	is 1 and 2 soft Health as Item 27 is other trau		SUZANNE MORIN / DAUGHTER 3903 LONG LAKE DRIVE			
Baltimore,	ges 1 at of He if Item	Ĭ	20a. Method of Disposition  1	Date 2	0c. Location - City or To	
<u>Ħ</u>	it. Pag irtmen irtant: njury		4□Donation 5□Other (Specify) BETH HAMEDROSH HAGODOL 03/2		ROSEDALE,	
Ba	permi Depar Impor any ir once	s li	21. Signature of Funeral Service Licensee  22. Name and Address of Facility SOL 8900 REISTERSTOWN			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Cerebral Throm busc	7		Onset and Death
-	/Medical Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):			
	ecuted ind transit	Examiner	cause Enter Uniderlying Cause (Disease or injury that initiated events c.			
60,	icate be executed physician and s the burial-transit	E E	resulting in death) Last  Due to (or as a consequence of):			
68760,		edical	d			
Box	Physician: The law requires that the death certific this certificate has been signed by the attending prat director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	•
о. В	ne dea the at hed fo	/sici	in the past 12 months?  1   Yes 2   No 9   Unknown   9   Unknown   1   Unknown   Unknown   1   Unkno		Month	Day Year
, P.O.	res that the de signed by the a be detached f	Ph.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
Vital Records,	quires en sigr uld be	ed by		1 □ Yes	s 2 No 3 Prol	pably 4 Unknown
eco	e law requir has been s le 2 should l	Completed		24a. Was an autopsy		psy findings available mpletion of cause of
a E	ician: The certificate h ector, page			perform 1 □ Yes 2	ied? death?	2 □ No
	ysician: The nis certificate h director, page	o Be	examiner?	h <i>(Check only one</i> ome 5 ☐ Resider	100	1
ס ר	iding Phys th. After this funeral dir	n: T	27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		<i>y)</i>
siol	tendir leath. tor: Al the fur	catic	2 Accident investigation M 1 Yes 2 No			
Division of	I or Attend after death. Director: / I in by the fi	Certification: T	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	eet and Number or Rura , State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only  Wedical Examine: On the basis of examination and/or investigation, in my opinion, death occur	and due to the ca	ause(s) and manner as	stated.
	To the H within 24 To the F complete	Medical	one) and manner stated.		d. Date signed (Month,	
	5 <b>7</b> ≦ 5					
			30. Name and address of person who completed cause of death (Item 23a) (Type Print)  A D D 130 R M D 673 A A T A B I D A  31. Date filed (Month, Day, Year)  32. Registrar's Signature	10-1	11010	61
			1440 CD 100B M 06734 HVIATIN Blud	) a MA	N 210	0/
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10b for partment of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 25 2010 5:11 PM **Physician** GLAZER PHILIP /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WORCESTER BER IN IYear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) BERLIN NURSING HOME Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** MD 1 X M 2 ☐ F Vrs 06/24/1926 216-20-4919 83 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other then "natural", or items 23a or 28a-f show any Injury or other traumetic event, it a Medical Era virus must be refifted at 10c. City, Town or Location 10b. County Baltimore 10a. State **Baltimore** 1 Tyes 2XXNo OCEAN-CITY WORCESTER MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8242 Brattle Rd. USA 21208 12901 WIGHT STREET, UNIT 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status WHITE 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify: Specify P 21215-0036 Completed by 3 Widowed 4 Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FINANCE BANKER 18. Mother's Name (First, Middle, Maiden Surname) R PHILI 17. Father's Name (First, Middle, Last) Be FRANK CECELIA GLAZER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21209 7301 TRAVERTINE DRIVE, #303 RICHARD SHURE/COUSIN 20c. Location - City or Town, State GLAZEF Itimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/28/2010 | BALTIMORE, 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, be Physician/Medical The law requires that the death certificate IF FEMALE 23d. Date of delivery yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy s certificate has b lirector, page 2 sh 1 ☐ Yes 2 DN0 26. Place of Death (Check only one, the Hospital or Attending Physician: 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin, MD Nowil Wajafi

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Haskins Halliwood March 26 2010 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and gumber) Baltimore Randallstown Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1**X**XM 2□ F 216-20-7977 11-16-1929 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 ☐ No BALTIMORE WOODLAWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6420 KRIEL STREET 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

BRICK LAYER

6420 KRIEL ST.

BETHLEHEM STEEL

18. Mother's Name (First, Middle, Maiden Surname)

BALTIMORE, MD

OLENA CHRISTIAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examination is a routiled at once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

10a. State

MD

6

17. Father's Name (First, Middle, Last) MATTHEW HASKINS

19a. Informant's Name/Relationship (Type. Print) RUBY E. HASKINS/WIFE

Director

Funeral

ģ

Be Completed

ပ

**Funeral** 

Director

**Physician** /Medical **Examiner** 

physician and s the burial-trans as signed to page

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Pomoval from State	Place of Disposition (N cemetery, crematory or	other place)	Date / 2.201		20c. Location - City or Town, State  BALTIMORE, MD				
	4 ☐ Donation 5 ☐ Other (Specify	y) -	ARBUTUS MEM		4-3-201						
	21. Signature of Funeral Service Licen	. Mirto		and Address of Facing Address		A. MORT BALTIMOR		SONS F.H., INC 21217			
	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):										
Physician/Medical Examiner	Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3d. Date of Month	*								
	Part II. Other significant conditions of				t I. 23	23e. Did tobacco use contribute to the cause of death 1 □ Yes 2 □ No 3 ☑ Probably 4 □ Unkn					
Completed by	Pleural effusi	uboli Octob	wid thus	kening		a. Was an autopsy performed?	topsy prior to completion of cause or formed? death?				
Be	25. Was case referred to medical examiner?				ce of Death (Chec	ck only one)					
	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ I	DOA Other: 4 🗆 I	Nursing Home 5	☐ Residence 6	☐ Other (S	Specify)			
ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 [		escribe how injury	occurred				
ertilic	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, street, factorify)	ory, office	28f. Lo	cation (Street and ty or Town, State)	Number or	Rural Route Number,			
edical Certification: To		nysician: To the best of my k niner: On the basis of exami and manner stated.									
ĕ	29b. Signature and title of certifier		2	9c. License numbe	r	29d. Date	signed (Mo	onth, Day, Year)			
	D Roggen			D35844 March 26 2010							
	30. Name and address of person who		em 23a) (Type, Print) Road Swit	c 108	Randa	Ustown	MO	21133			

State Registrar

31. Date filed (Month, -Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BEVERLY HINES 12:47 PM ANN MARC Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY BALTIMORE MARYLAND MEDL OF If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Hours November 29,1940 Count Maryland Director 216-38-4321 69 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BelAir 1 Yes 2 No Md. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 1314 Southwell Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Should be mod. th and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Admin. Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olivia Corben Clarence Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau BelAir, Md. 21014 1314 Southwell Lane Spouse Robert E. Hines Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3-30-2010 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Signature of Funeral Service Licensee 9705 BelairRd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ MY OC. AR DIAZ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine sician and burial-transit EVERE Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): physician as the burial-Physician/Medical Records, P.O. Box 68760 attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Yes signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 a autopsy 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗘 1 Tes မ 1 Npatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 5 Pending 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: All completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F only one) 29d. Date signed (Month, Day, Year) MARCH 24, 2010 and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE ND 21201 GNEENE

DHMH 17 Rev 7/2009

State Registrar 32. Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM 1200 Medical ility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-30-0902 1 🔀 M 2 🗆 F Months Hours Marchay, Year) 1933 77 MD Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10c. City, Town or Location 10d. Inside City Limits notified at Director Baltimore Essex 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 21221 USA 903 Hauf Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces þ 1 Never Married 2 Married Yes Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ray Machinery Sheet Metal Worker 8th Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ပ Anna Noon William Edgar Hauf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Left Wing Drive Balto. MD 21220 David Hauf /son other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 20c. Location - City or Town, State Date 3/29/10 1 ☐ Burja PX Cremation 3 ☐ Removat from State Baltimore MD on 5 Other (Specify) vice Lick 21. Signatur 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last anding physician use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months? Pregnant at time of death Yes 2 No isigned by the a g 🔲 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown Records, 1 Yes 2 No been signated by the second of Completed . Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and ad pleted cause of deal Date filed (Month, Day, Yea State MAR 30 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30 M Holtzman 2010 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner Alumbia DWarc 5. Social Security Number (In yrs. last If Under 1 Year If Under 24 Hrs. 8. Hours Min. Birthplace (State or Foreign Country) 7. Age Date of Birth (Month, Day, Year) **Funeral** Months Days 429-10-9353 Director AR Aug 27, 1914 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be retified. 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Director AR Pulaski Little Rock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 N. Coolidge 72205 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 至 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Newspaper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Russell Smith Florence Rose Williams ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Fugate daughter 8517 Nicole Ct. Ellicott City, MD 21043 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Crest Memorial Park 4 □ Donation 5 □ Other (Specify) 3 APRIL 10 Little Rock, AR 21. Signature of Funer Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 se, or complications that caused the death.

List only one cause on each line. 23a. Part 1. Enter the dis Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Muscardia /Medical Due to (or a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery detached for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₽ 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia

State Registrar Owcuis

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15 P.M March 2010 Mary Christine Henn Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 202 Burkwood Court, Apt. E Bel Air Harford 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep. 30 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Hours Min Months **Director** Yrs 1925 220-12-3398 84 Usual Residence of Decedent or 28a-f show e notified at 10a, State be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🙀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 202 Burkwood Court, Apt. E 21015 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William (unk) McCormac Viola (unk) Wooten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Henn / Husband 202 Burkwood Court, Apt. E, Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ∑XBµrial 2 □ Çremation cemetery, crematory or other place) 4 Monation Other (Specify) 3/30/2010 Sykesville, Maryland View Mem. Park Sir 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, when cause on each line. Approximate shock, or heart failure. List Immediate Cause (Final Onset and Death Vehidration Physician, disease or condition resulting in death) 10.45 Medical Due to (or as a consequence of): Examiner ohay: week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or). neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Years that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnam 9 ☐ Unknown 1 ☐ Yes ≥ ₺ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 10 S 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed' 1 🗆 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 - No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

24 hours a Funeral I within 2

> State Registrar

29b. Signature and title of certifier

Wendy Kluss 31. Date filed (Month, Day, Year) \*\*AR 30 2010

Klusz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701

32. Registrar's Signature

Kenwood

29c. License number

D 31295

Bank

10-0

29d. Date signed (Month, Day, Year)

3/26/10

2/100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:05PM Hamilton 4 8 1 26 2010 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fairhaven Sykesville Carrol1 8. Date of Birth (Month, Day, Year) 03/16/1924 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F Maryland 216-20-1488 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Md Carrol1 Sykesville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7200 Third Ave 21784 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify: 3 Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  $\stackrel{\text{Elementary/Secondary (0-12)}}{12 Yrs}. \\$ College (1-4or 5+) Government Employee Internal Revenue Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Zeller Ottilia Huber ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Davidson (Niece) 1490 Bennett Rd. Eldersburg, Md. 21784. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral 03/30/2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel P.A. 21. Signature of Funeral Service License P.O. Box 195 Sykesville.Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsetiand Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Myocard da /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physiclan: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2. No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□Yes 2□No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and the of dertifie

Records, P.O. of Vital Division

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jan MD 31. Date filed (Month, Day, Year)

MAR 30

1645

32. Registrar's Signature

29c. License number

Idershur MD 21784

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5 per FH G902 4 / 12/2010 WS Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month 1040 OM 2010 March 24 Peggy Hodges Ann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE AGNES 4050, TRL If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 212 36 - 976 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F March 8,1939 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1601 Popland Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Mona Elizabeth Heron Francis C. Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband 1601 Popland Street, Baltimore, MD 21226 James D. Hodges 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/29/10 Lake View Mem. Park Sykesville, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

Eline Funeral Home Reister

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11824 Reisterstown Road Reisterstown, MD 21136 Approximate Interval Between Onset and Death Immediate Cause (Final Acure MYOCKRPIAL INFARCTION nours disease or condition resulting in death) Due to (or as a consequence of): CORONARY TRANS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ➡ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PulmenAvy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner death certificate be executed Division of Vital Records, P.O. Box 68760.

and burial-tran attending physician for use as the buria the s been signed by t should be detach director, page 2 should has certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica After this funeral c completely filled in by the

Physician/Medical ğ Completed Be Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examine must be notified at

Physician

/Medical

altimore, Maryland 21215-0036

Medical

State Registrar 4 Homicide

(Check only one)

29b. Signature and title of certifier

MAHMOUD

29a, Certifier

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29c. License number

P20657

29d. Date signed (Month, Day, Year) March, 241, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE, BALTIMORE, MD. 21229

ALDANDASH 31. Date filed (Month, Day, Year) WAR 30 32. Registrar's Signature

MO

Phillip Holmes

10-02345 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		Johns Hopkins Hospital Baltimore			NA	
Funeral			8. Date of Bir	rth(MM/DD/Y	(YY) 9. Birth Foreign	place (State or
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, MD 21215-0036 and 2 shoud be filed within 72 hours after death eath and Mental Higgine. It is marked other than "matural", or iten fraumatic event, the Medical Examiner must traumatic event, the Medical Examiner must		CRACIE CHORLE   MOTHER 549   CECLONIA AVE  20a. Method of Disposition (Name of cemetery, crematory or other place)	- DAC	1200 Locatio	MD, City or To	2/206
E E E E		1 🔀 Burial 2 Cremation 3 Removal from State crematory or other place)	1	200. 2004(10		own, state
ti. Pag tment rtant:		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barrier	3/10	Cocke	45020	LE, MD.
Baltimo permit. Page Department o Important: injury or ott		21. Signature of Funeral Service Licensee	73 /	-UNC.	KAL 1	40 MC
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n				Approximate Interval
Modical		failure. List only one cause on each line.	, , , , , , , , , , , , , , , , , , , ,	,,		Between Onset and Death
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - trans		1 Notice Company Page 1 Supply	Bd. Describe h		urred	
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To To	Med	and manner stated.  29b. Signature and title of certifiery 29c. License number			gned (Month	
		O.C.M.E.		March 24		
	}	30. Name and address of person who completed cause of death (Item 23a)				
HV		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201			
	ate	31. Date filed (Month, Day, Year)  MAR 3 0 2010  MAR 3 0 2010  MAR 3 0 2010		-		
Regist	rar	MAR 3 0 2010 Chier B. Marie				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ Maurice 2010 L. Irvin 3:00p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 157 Sanford Avenue Baltimore Catonsville 8. Date of Birth (Month, Day, Year) Dec. 12, 1920 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 M 2 D F Maryland 215-12-5055 89 Director Dec. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 29a-f ehm er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore <u>Catonsville</u> 10e. Street and Number 10g. Citizen of What Country? Funeral 157 Sanford Avenue 21228 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 \( \text{No } 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber 9 Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Irvin Gertrude Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Harriet A. Nypaver/ Daughter .553 Barrett Road, Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Marchat30. cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland permit. f Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 21. Sign turi 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Conce Physician. Lun disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate leaves after death.

Funeral Director: After this certificate has been signed by the attending phys attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day ed by the a 1 U Yes 2.9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Pranticiper To the basis of ny knowledge death occurred at the fine date and place and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D34907 Kru 30. Name and address of person who completed COUNT (15 Bull of Antilol Colombia)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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gistrar's Signatur

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Funeral	7	5. Social Security Numberunk 6. Sex 7. Age (In yrs. last	D		If Under 24Hrs.	8. Date of Birtl	n(MM/DD/YYYY) 9. Bi Forei	rthplace (State or
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5-0 lled wi Hygie I other	ပ၂	17. Father's Name (First, Middle, Last)		18.			Maiden Surname)	
2121 ould be fi Mental marked	o Be	FLOYD JACKSON  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Add	ress (Street a		MARY RAN Rural Route Num	ber, City or Town, Stat	e, Zıp Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sh numatic event, the Medical Examiner must be notified at once	ř	CRYSTAL LEE/SISTER	6102 MA			ALTIMORI	E, MD 2120	)6
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Physician		failure. List only one cause on each line.		, ,				Between Onset and Death
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Box 68760, he death certificate be event the attending physicial hed for use as the buria	Physician/	4 Pregnant at time of deat  1 Yes 2 No 9 Unknown 9 Unknown	th 5 Other	(Specify)			1	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	F.	Part II. Other significant conditions contributing to death but not res	sulting in the under	lying cause giv	ven in Part I.		obacco use contribute	
P.O. es that the signed by be detac	ğ					1 Ye		obably 4 Unknown
ords, P w requires the second of the second	lete					24a, Was autor	osy prior to	autopsy findings available o completion of cause of
eco he law ite has	Completed					1 Yes	rmed? death′ 2 No 1 ✓	
Division of Vital Records, tal or Attending Physician: The law requir is after death.  1a Director: After this certificate has been silled in by the funeral director, page 2 should b	BeC	25. Was case referred to medical examiner?		_ io	of Death (Check			
Vita hysici	15 B	1 Ves 2 No Inpatient 2 V E	R/Outpatient 3			ing Home 5	Residence 6 Oth	ner:
n of ding P h. After	Ë	1 Natural 5 Panding FOUND	FOUND:		es 2 🗸 No	Subject har	nged himself	
Visior or Attend frer death Sirector: in by the	icati	2 Accident Investigation Mar 27, 2010 28e. Place of Injury - At hor	ne, farm, street, fa	ctory, office bu	ilding, etc.			Rural Route Number, City
Divis	Certification:	Suicide 6 Could not be determined (Specify) At home				or Town, S 7869 Levy St	State) reet, Glen Burnie, M	ID .
Hospital 24 hours Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred	at the time, date	e and place, an	d due to the cau	se(s) and manner as s	tated.
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	d/or investigation,	29c. License		at the time, date	29d. Date signed (f	
	Σ	29b. Signature and title of certifier		O.C.M			March 27, 201	
		30. Name and address of person who completed cause of death (Item 2	23a)					
7		Ling Li, MD Assistant Medical Examiner 111 B	Penn Street, E	Baltimore, M	MD 21201			
	State	31. Date filed (Month, Day Year) 32 Registrar's Signatur		0				
Regi	stra	MAR 3 0 2010 Venus S.	Back					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ DYNER 50 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner NORT HUSP TOWN 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number If Under **Funeral** <sup>Year)</sup> 1976 Days Months M 2 □ F 216-17-6961 Director Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Directo Gwynn Oak Baltimore Maryland 1 Yes 2 XNo 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21207 USA 28 Cedar Heights Ave., Apt. B 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 X Never Married 2 Married Yes 2 XNo <u>۾</u> Maryland 21215-0036 hours after Black 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Disabled 12 Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dedra Green Calvin Joyner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2328 Druid Park Drive Baltimore, Maryland 21215 Janine McNair, Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/29/10 4 Donation 5 Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licenses 22, Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Alice Iser 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to (or as a consequence of the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 WUnknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) exam Other: 2 🗌 No ျှ Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 S 27. Mar er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accider
Suicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signath MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Day Month 6:45 PM Belle Johnson 2010 Omega 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Keswick Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 89 NC 216-18-9633 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 TXYes 2 □ No Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5818 Greenspring Ave 21209 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes ♣☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify Specify: Black 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12th grade Teacher 6yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Hardy Sandy Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5818 Greenspring Ave, Baltimore, Md 21215 Charlene Butler-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 3/31/10 Arbutus, Md March Fr H West 21215 Baltimore, Md 4300 Wabash Ave, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final caneer disease or condition resulting in death) Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 No

**Physician** /Medical Examiner Examiner

**Physician** 

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

ed other than "natural", or items event, the Medical Examiner ma

item 27 Is marked other traumatic ev

permit. Pages 1 and 2 sh Department of Health and Important; If item 27 Is m any Injury or other traum once.

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s 1 and 2 should be filed within 72 hours after the Health and Mental Hygiene.

21215-0036

Baltimore, Maryland

/Medical

10a. State

MD

certificate be executed attending physician and for use as the burial-trai signed by the a

certificate

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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or Attending Physician:

Completed by page After thi funeral

Physician/Medical

Certification: To Be

Medical

IF FEMALE:

23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No

						1∐ Yes	2 MNO	1 Li Yes 2
5. Was case referred to medical				26. Place of Dea	th (Cl	heck only o	ne)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome	5 🗆 Resi	dence	6 □Other (Specify)
7. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d.	Describe	how inju	y occurred

1 Natural

29a. Certifier

(Check only one)

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

(Month, Day Year) determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

e how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Ycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier > 7 Finbelle

29c. License number 01365

29d. Date signed (Month, Day, Year) March 26, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. BABEUE NovegREGOR, 700 W. 40 th ST-BALFINGRE, 020 21211

State Registrar R 30 2010

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Dorothy Mae Jones 03 2010 2:35a. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Future Care Nursing Home Reisterstown Year) 8. Date of Birth (Month, Day, 10 15 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 🔀 F 10 76 NC 241-48-5829 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Pikesville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 U.S.A. 4 Sturgis Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Machine Operator Alpharma 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magnolia Atkins Lucious Landis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sturgis Ct., Pikesville, Md 21208 Margaret Sanders-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/3/10 Woodlawn, Md of Funeral Service Licenses March F/H West Md 21215 4300 Wabash Ave, Baltimore, inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one c Interval Between Ønset and Death Immediate Cause (Final disease or condition resulting in death) llrum Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

**Director** 

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner burial-trar attending physician for use as the buria Physician/Medical Be Completed by certificate e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director. p. Certification: To

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	►d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
COP	D	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Dec	th (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Mann Death  1 Autural 5 ☐ Pending 2 ☐ Accident investigatio		28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determin	e 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Greene Tres

State Registrar

within 2.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

2 ☐ Medical Examiner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ hnson 1:5 MORO Medical 4a. Facility Name (if not institution, **Examiner** nda l 15tou **Funeral** Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 1 🗆 M 2 💆 Months Director Yrs. or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County must be notified at 10d. Inside City Limits Director 1 Yes 2 No Vistown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuba, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be other traumatic event, 17. Father's Name (First, Middle, Last) ၉ Page 1 and 2 st ment of Health a tant: If item 27 is ISTEI permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other I 20b. Place of Disposition (Name cemetery, crematory or oth 20a. Method of Disposition Netific of Disposition

■ Burial 2 □ Cremation 3 □ Removal from State matory or other place 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 23a. Part 1. E. fe the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or in art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) y ma Medical Due to (or as a con ) quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 9 Yes 2L the signed by Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown page 2 should l een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' this certificate 2 🗌 No Yes 2 Qu 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 ANO ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury 5 Pending Accident 3 Suicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1/2 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Cha 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 12:11 26,2010 MLD MANCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 € M 2 □ F 215-40-8177 76 June 26 Director 1933 MD Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Injury or other traumatic event, the Michael Eventine quet be notified at MD Howard Glenwood 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3404 Sharp Road 21738 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald Earle Johnston Muriel Isennock ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Sharp Rd., Glenwood, MD 21738 Carolyn K. Johnston (spouse) Baltimore, 20a. Method of Disposition

¼ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fork UMC Cemetery 3-31-10 Fork, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15005 ps Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? performe 2 No 1 Tes 1 ☐ Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ Mo 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

march 26 2010

ONE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Lottie M. Keys March 23 11 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5100 Railroad Avenue St. Dennis Social Security Number 6. Sex . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours May 17, Year 935 Maryland Director 213-32-9365 74 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director 1 🗆 Yes 2 No MD Baltimore St. Dennis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5100 Railroad Avenue 21227 United States Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Fishpaw Rose Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Riverwood Way, Curtis Bay, MD 21226 Linda Lough - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Meadowridge
Memorial Park 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3-27-2010 Elkridge, Maryland of Fun Sign tu ervice Li lensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ erebrovascular disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's 20 No Other: 1 🗌 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) home Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide

Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director:

> State Registrar

Medical

29a. Certifier

(Check

only one)

30. Name and address of p

31. Date filed (Month, Day

MARTIC

determined

within 2 To the F

leted cause of death (Item 23a) (Type, Print)

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

258360

29d. Date signed (Month. Day, Year)

MARCH 25

JAZZINORE, DI

2010

21225

29c. License number

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Dep   <b>S</b> tate Registrar <i>Ce</i>	ertificate of Death	-	
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3 Time of Death
	Physicia		JEAN K. KAC		MArch	12:30 NAS: 51
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	=,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Catered Living of Cockeysville	Cockeysville		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, )  Jan 23,	9. Birthplace (State or Foreign Country) 1912 Russia
	Director	-	216-40-0703 98 Yrs. Usual Residence of Decedent		Jail 2J	
	filed within 72 hours after death with the Maryland Hydiene. the than "natural", or items 23a or 28a-f show with the Madical Examinar must be redified at		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 □ Yes 2 📉 No
	e Mai	Directo	Maryland Baltimore Timon			
	ift th	Dire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	ath w	sral	2419 Eastridge Road  11 Marital Status 12. Was Decedent Ever in U.S. 13	21093	ecify Ves or No-	USA 14. Race - American Indian,
	item item	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
336	urs aff	by	If Yes, Give Year or Dates:	1 ☐ Yes 2 ሺ No Specify:		Specify: White
ק ק	2 hou	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation		6b. Kind of Business/Industry
21215-0036	ithin 7 ne.	du e	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work  DO NOT use retired)		Own Home
2	ed will had be the the the the the the the the the th	ပိ	12 02 Hor 17. Father's Name ( <i>First, Middle, Last</i> )	nemaker	e (First, Middle, Ma	
Maryland	l be fi	Be		Dora	_	Shulick
Ž	hould id Me mark matic	ဍ	Aaron J. Kligerman  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	iling Address (Street and Number or Rui		
<u>⊠</u>	d2s Ithan 127 is trau		Toda Maria Talana Talan	9 Eastridge Road, 1		
ē,	f Hea					Oc. Location - City or Town, State
9	Pages ient o nt: If i	- 24		idge Cemetery 3/3	1/10	Pikesville, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Examinar man be notified at once.	16 2 19	2. Suchare of Fungral Service Lion 9	22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road	e of Dula	ney Valley Inc.
	ç		23a. Part 1. Friter the disease, or complications that aused the death. Do not enshow or heart failure. List only one cause on Jach line.	nter the mode of dying, such as cardiac	or respiratory arre	et, Approximate Interval Between
			shock or he rt failure. List only one cause on Jach line.	Dementica		Onset and Death
1	Physician /Medical		Immediat: Cause/Final disease or condit on resulting in	Be WE ! HE		
	Examiner					
	B #	ne.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
J	ecute and transi	Examiner	that initiated events C.			
90,	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	E	resulting In death) Last Due to (or as a consequence of):			
28260,0	physi the t	edical	d			
9 X	certifi nding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	_		23d. Date of delivery
Box	atter for u	Physician/M	in the past 12 months?  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other <i>(sp</i> ec <i>ify)</i>		Month Day Year
P. O.	the contraction the achec	hysi	9 ☐ Unknown			
Ψ,	s that gned l	y P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to the cause of death?
ğ	w require s been sig should b	pe	Forlure To Thrive		1 ∐ Ye	s 2 ☐ No 3 ☐ Probably 4 💆 Unknown
Division of Vital Records,	law re as be 2 sho	Completed by			24a. Was an autopsy	prior to completion of cause of
<u> </u>	The ate h	5			perform 1 □ Yes 2	death? No 1 ☐ Yes 2 ☐ No
/ita	cian; sertific ector,	Be (	25. Was case referred to medical examiner?	Other:	th (Check only one	4 Assisted
of o	Physi this c	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time	tient 3 DOA 4 Nursing H	lome 5 ☐ Reside 28d. Describe ho	nce 6 Other (Specify)
'n	ding P	ig	1 Natural 5 ☐ Pending (Month, Day, Year) Injur		254. 25551155 115	,,
Si	death death ctor: y the	ficat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm,		28f. Location (Str	reet and Number or Rural Route Number,
<u>S</u>	after after I Dire	Certification: To	4 ☐ Homicide determined building, etc. (Specify)		City or Town	, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To the H within 24 To the Fi complete	Medical	one) A CRNP and manner stated.	29c. License number		9d. Date signed (Month, Day, Year)
	5 vit	2	29b. Signature and title of certifier	R125808		03/29/2010
			and address of account of the strict of the			-71-12010
	1,7		30. Name and address of person who completed cause of death (item 23a) (Type 200 and address of person who completed cause of death (item 23a) (Type 200 and address of person who completed cause of death (item 23a) (Type 200 and address of person who completed cause of death (item 23a) (Type 200 and address of person who completed cause of death (item 23a) (Type 200 and address of death (item 23a) (Type 2	South Air C	de 203	BALTO MD 21209
	St	ate	30. Name and address of person who completed cause of death (Item 23a) (Type 28.3.)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Minally Jack	-1-	
	Regist		MAR 3 0 2010 Clevery 12. 19 acres			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Albin O. Kuhn 4:00a March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 7433 Woodbine Road Woodbine 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Days Hours Jan. 31 1916 1 ▼ M 2 □ F Director 219-36-8671 94 Usual Residence of Decedent and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director MD Carrol1 Woodbine 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21797 7433 Woodbine Road USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 V Yes 2 No WWII Black, White, etc. þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) University of Md. administrator permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tr</u> onee. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Slonaker Kuhn Clara May Owings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eileen L. Kuhn (spouse) 7433 Woodbine Rd., Woodbine, MD 21797 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-27-10 West Friendship, MD McKendree Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel .0. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Consestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD, atrial fibrillation, hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? prostate cancer, abdominal aortic aneurysm 24a. Was an this certificate has ral director, page 2 performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ည 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural iniury 5 Pending To the most after death.

Within 24 hours after death.

To the Funeral Director: Aft work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Cian

Gei

address of person who completed cause of death (Item 23a) (Type, Print)

an Rescue TTC M 700 Get

Registra Signat

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275, Cotons wille MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARTH 25, 10:30 A<sub>M</sub> Charles Joseph Konya Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10808 Larkmeade Lane Potomac Montgomery 5. Social Security Numbe . Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 PA **Funeral** Months Days Hours Min 160-03-6854 5/9317, Pro18 Director 91 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director MD Montgomery Potomac 23a or 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10808 Larkmeade Lane within 72 hours after death with 20854 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ō Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give SpecifWhite 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other than you or other traumatic... Diplomat Foreign Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Francis Konya Katy Hockle 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Wolford, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8360 Greensboro Dr. #417 McLean, VA 22102 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 3/27/2010 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Rapp Funeral & Cremation Svcs M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Melanoma disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi ause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Certificate: To Be Completed 1 ☐ Yes 2√√ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 2√x√No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔄 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D22775 3/26/2010 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Barr, MD; 5454 Wisconsin Ave. Bethesda, MD 20814 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

	1	For State Registrar		Ce	ertificate of L	Death	Re	g. No.	
Physiciar	n	1. Decedent's Name (First, Middle, Last,	)				2. Date of Death Month	Day Year	3. Time of Death
/Medica Examine		Olga Kritikos  4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	March 2	4. 2010 4c. County of Death	
Examme		622 S. Oldham Str				ore City		N/A	
Funeral Director		059-14-6428	x ☐ M 2 🖾 F	n yrs. last birthday 92 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 23	Year) 9. Birth Cou.	place (State or Foreign Intry) Ceece
land t	-	Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Medical Experient must be recified at once.	힏	Maryland N/A		Baltimo	re				1 X Yes 2 □ No
7 28g	Director	10e. Street and Number			10f. Zip Code		11	Og. Citizen of What Cou	intry?
23a (23a (23a (23a (23a (23a (23a (23a (		622 S. Oldham Str	e <b>t</b>		2122	4		U.S.A.	
tems Fr	Funeral	11. Warta Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	
al", or	2	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ∐Yes 2 <b>Z</b> No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: Whi	te
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ther int,		6th Grade  17. Father's Name (First, Middle, Last)	N/A	walt	.ress	18. Mother's Name	(First, Middle, M		
ked o	To Be	Harry Janis				Spathou	la Unkno	own	
umat umat		19a. Informant's Name/Relationship (7)	ype. Print)	19b. Mai	iling Address (Street	and Number or Rura	al Route Number	, City or Town, State, Z	ip Code)
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tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify,	)	T	Cemetery		29,2010	Baltimore	, MD
Import any ir		21. Signature of Funeral Service Licens	ee	(	22. Name and Addres Charles S.	Zeiler &			10.6
	$\dashv$	3a. Part 1. Enter the disease, or comp	lications that caused the	e death. Do not e	6224 Easte	rn Ave. ng, such as cardiac	Baltimo: or respiratory arm	re, MD 212 est,	Approximate
ysician		Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
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aminer		Sequentially list conditions,	b	Hyper	tensin			Pan A. 3 ease	20 Yust
±g.	ine	cause (Disease or injury	Due to (or as a c	unsequence of):					
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burie			d						
	Medical	·= == · · · · · ·	<u> </u>				- 49		
L use	Physician/N	ZSD. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		B   Ectopic pregnanc	:v		23d. Date of deli Month	ivery Day Year
ed fo	sici	in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown		Other (specify)	,		Month	Day real
be detached	F.	Part II. Other significant conditions co	ontributing to death but r	not resulting in the	underlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	the cause of death?
d be	d b			,	, , , , , , , , ,		1 🗆 Y	es 2.⊠″No 3.∏ Pr	obably 4 🗆 Unknown
should	Completed						24a. Was a	n 24b. Were au	topsy findings available
age 2	g						autops	med? death?	completion of cause of
tor, p	Be	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes h (Check only or		2 🗆 NO
direc		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpat	ient 3 DOA Oth	ner: 4 \sum Nursing Ho	me 5 Resid	ence 6 Other (Spe	cify)
neral	Ĕ	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y	(ear) 28b. Time	e of 28c. Injur	ry at k?	28d. Describe h	ow injury occurred	
the fr	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
d in by	Certification: To	4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ural Route Number,
		29a. Certifier 1 Certifying Ph	ysician: To the best of aniner: On the basis of earth manner state	xamination and/or	eath occurred at the ti r investigation, in my o	ime, date and place opinion, death occur	, and due to the ored at the time, o	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
Funera etely fills		(Check only 2 Medical Examone)							
To the Funera	Medical C	(Check only one)  2 Medical Examone)  29b. Signature and title of certifier	and manner state		29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		one)		mp	29c. Licens	R / 86 5		3/26/	
To the Funera		one) 29b. Signature and title of certifier	D KIDO	th (Item 23a) (Typ	D 3	R / 86 5		- /	
within 24 hour volumer to the Funers completely fills		29b. Signature and title of certifier  29b. Name and address of person who of Rm 20b	D 12,700 completed cause of dea	ith (Item 23a) (Typ	03	1865 paet	md	- /	
within 24 hours after death  To the Funeral Director: completely filled in by the start of the s	Medical	29b. Signature and title of certifier  30. Name and address of person who of	D KIDO	ith (Item 23a) (Typ	D 3	B / 865 Daet	md	- /	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/  $\underline{2010}^{\text{Year}}$ 26. 7:00pm Pauline Keeney March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Transitions Healthcare Sykesville Carroll 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Days Hours Min 08-08-1913 Country)
Maryland Director 218-32-2496 96 Usual Residence of Decedent of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 NOrth Drive 21144 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give 3 Nidowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assmbly Line llyears Black & Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Peter Smith Violet Burnham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Lorraine Stoner (Daughter) 733 Washington Rd. Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1. Department of I Important: If its any injury or o' 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Finksburg Cemetery 3-31-2010 Finksburg, MD Signature of Funeral Service Licenses 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Approximate Interval Between nset and Death mmediate Cause (Final Physician/ omentra disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a sunsequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this confidence has a confidence because the confidence of the confidence has a confidence because the confidence has a confidence because the the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Funeral Director After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29

State Registrar 31. Date

nth, Day, Year)

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20110

		_	For State Registrar		. ,	Certificate of I			Reg. No.	0 09641
	Physicia		1. Decedent's Name (First, Middle, La LINDA J. CLA		ELLY			2. Date of Dea	ath 2ay 2 <sup>Yea</sup>	3. Time of Death 8:10 a M
12	Medic Examin		4a. Facility Name (if not institution, give				or Location of Death		4c. County of De	eath
			Greater Baltimor  5. Social Security Number 6.		Center	Towso		O Date of Blid		timore
	Funeral Director			1 M 2 X F	61	Yrs. Months Days	Hours Min.	8. Date of Bird Sept. 5	y, Year 948 New	Birthplace (State or Foreign Country) V Jersey
	ind show at	o.	10a. State 10b. County	1	10c. City, Tov	n or Location				10d. Inside City Limits
	Maryla 28a-f s atified	rect	MD Balt	imore		Timonium				1 🗆 Yes 2 🕱 No
	with the I s 23a or 2 ust be no	<b>Funeral Director</b>	10e. Street and Number 2145 Kimrick P	lace		10f. Zip Code 210	193		10g. Citizen of What	Country?
980	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 【▼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1  Yes 2  No		ecify Yes or No- Rican, etc.)	Black, Wi	merican Indian, hite, etc. <b>Vhite</b>
Maryland 21215-0036	hin 72 hou ne. than "natu the Medical	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)		4"	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired) Senior Assoc	durina most of worki	ing ector	16b. Kind of Busines	s/ Johns
d 2	filed wit al Hygie d other vent, th	Be C	17. Father's Name (First, Middle, Last,	<del> </del>		Development	18. Mother's Name		Hopkins Ur	ilversity
/lan	d be fil Aental arked aric ev	ပ	Leon	Claremon				rice	Cohe	en
	427		19a. Informant's Name/Relationship (		19	o. Mailing Address (Street 2145 Kimric				, ,
Kelly Baltimore,	Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemete	of Disposition (Name of ery, crematory or other place top Serv. Co	ce)	Date 27/10	20c. Location - City Towson,	·
n Kelly <b>Baltimo</b>	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service	<sup>hsee</sup> William	G. Da	J I	ss of Facility Ruc		on Funeral	Home, Inc.
Claremon	Trysician/	i Ui	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	he death. Do					Approximate Interval Between Onset and Death HOURS
	/ Medical Examiner		resulting in death)	Due to (or as a c	consequence	,				
Ta la				TAN TI 4		INTER PERMIT	TE DE A			3 YEARS
$\geq$		<u>ē</u>	Sequentially list conditions, if any, leading to immediate	b. —		MPLEX EPIL	2017/			1
Linda	uted Id ansit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events.	b. Due to (or as a c			20137			
Linc	e be executed ysician and e burial-transit	lical Examiner	cause. Enter Underlying	b. —	consequence	of):	<i></i>			
Linc 8760	tificate be executed ng physician and as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence	of):				
Lind Box 68760	e death certificate be executed the attending physician and shed for use as the burial-transit	ıysician/Medical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a c	consequence consequence pregnancy Fetal deat	of):			23d. Date of o	
Lind s, P.O. Box 68760	res that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 N No	Due to (or as a c  Due to (or as a c  Due to (or as a c  d.  23c. If yes, outcome of	consequence consequence pregnancy Fetal death	of):  of):  h 3 □ Ectopic pregnance 5 □ Other (specify) □	су		Month	delivery Day Year to the cause of death?
Lind cords, P.O. Box 68760	w requires that the death certificate be executed is bean signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	Due to (or as a c  Due to (or as a c  Due to (or as a c  d.  23c. If yes, outcome of	consequence consequence pregnancy Fetal death	of):  of):  h 3 □ Ectopic pregnance 5 □ Other (specify) □	су	1 🗌 \	Month  bacco use contribute  Yes 2 ★No 3 □	delivery Day Year  to the cause of death?  Probably 4 Unknown
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Lind Division of Vital Records, P.O. Box 68760	he Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. The law peep is a person of the strain Director. After this certificate has been signed by the attending physician and ipleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c  C. Due to (or as a c  d. 23c. If yes, outcome of 1  Live Birth 2  4  Pregnant at ti 9  Unknown  contributing to death but  Hospital: 1  Inpatient 28a. Date of injury (Month, Day, Y building, etc. (5)	pregnancy Fetal death ime of death not resulting  t 2 ER/O (fear) 28b At home, fa Specify)	of):  h 3	even in Part I.  ace of Death (Checker: 4 \sum Nursing Hore) y at 2.  Yes 2 \sum No	24a. Was a autop perfor 1  Yes sonly one)  me 5 Resid 28d. Describe he 28f. Location (S City or Town	Month  bacco use contribute  Yes 2 No 3 □  an 24b. Were a prior to death' 2 No 1 □ Y  lence 6 □ Other (Spe ow injury occurred  treet and Number or F n, State)	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of? Pres 2 No  ecify)  Rural Route Number,
Lind Division of Vital Records, P.O. Box 68760	I or Attending Physician: The law requires that the death certificate be e after death.  Director. After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the burit	Medical Certificate: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c  C. Due to (or as a c  d.   23c. If yes, outcome of 1  Live Birth 2  4  Pregnant at ti 9  Unknown  contributing to death but  1  Inpatient 28a. Date of injury (Nonth, Day, Y)  28e. Place of Injury building, etc. (8)  yesician: To the best of my niner: On the basis of example of the contribution of the contr	pregnancy   Fetal deathme of death   Fetal deathme of death     Fetal deathme of death     Fetal deathme of death     Fetal deathme of death     Fetal deathme of death     Fetal deathme of death     Fetal deathme of death     Fetal deathme of death     Fetal deathme of death	of):  h 3	even in Part I.  ace of Death (Checker: 4 Nursing Hory at ?? Yes 2 No	24a. Was a autop performent of the second of	Month  bacco use contribute  Yes 2 No 3 □  an 24b. Were a prior to death' 2 No 1 □ Y  lence 6 □ Other (Spe ow injury occurred  treet and Number or F n, State)	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of? fes 2 No  ecify)  Gural Route Number, stated. e cause(s) and manner stated.
Lind Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a c  C. Due to (or as a c  d.   23c. If yes, outcome of 1	pregnancy Fetal death mot resulting  t 2 SER/O  fear)  28b. At home, fa Specify) y knowledge, mination and/est of my knowledge.	of):  of):  h 3	ven in Part I.  ace of Death (Checker: 4 Nursing Hory at ??  Yes 2 No  date and place, and on, death occurred at 6 firm, date and place	24a. Was a autop performence of the second o	Month  bacco use contribute  ves 2 No 3   an 24b. Were a prior to death 2 No 1   lence 6 Other (Spriow injury occurred  treet and Number or Fin, State)  use(s) and manner as and place, and due to the case of a death 3   29d. Date signed (Mor 3 12 5 1)	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of? (es 2 No ecify)  Rural Route Number, stated. e cause(s) and manner stated. se that d. inth, Day, Year)

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State o	f Ma	aryland	-	artment <i>rtificate</i>				lental Hy	gien Reg. N			on all a
Physicia /Medic		1. Decedent's Nam	ne (First, Middle	le, Last)  JAM.	ES	- 1	Ea	115				2. Date of De Month	D	\$2	Year 10	3 Time of Death / 3. 20 A M
Examin				n, give street and nu eneral Hospi				4b. City, 1		lumbi			40		of Death ward	
Funeral Director		5. Social Security N 269-28-667	71	6. Sex 1 🖾 M 2 🗆 F	7. Ag	je (In yrs. la 7	st birthday) 75 Yrs.	If Under	1 Year Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D April 2	rth a <i>y, Year</i> 5 <b>,</b> 19	") 934	9. Birthp Cour Ohio	place (State or Foreign ntry)
/land		Usual Residence o 10a. State	f Decedent 10b. County			10c. City,	10c. City, Town or Location								1	0d. Inside City Limits
filed within 72 hours after death with the Maryland Hygiene. Hygiene. the Hygiene than "natural" or items 23a or 28a-f show ent, I as it wife I had a feet it wit oust by redified at	Director	Maryland	Howard	d			Columbia						1 ☐ Yes 2 🙀 No			
ter death with the Marylan items 23a or 28a-f show from roust by redified at		10e. Street and Nu 5656 Th	<sup>mber</sup> nicket La	ane.			10f. Zip Code 21044						10g. Citizen of What Country?  U.S.A.			
ems 20	Funeral	11. Marital Status		12. Was Dec			. 13.\	Was Decede			Origin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Ra	ce - Americ	
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Menta narked natic e	2	Irwin I										rstner				
ulth and 27 Is n r traun		19a. Informant's N Brigitta		ship <i>(Type. Print)</i> (Wife)				ng Address Thicket				rai Route Numi ia, Mary				o Code)
of Hez		20a. Method of Dis	sposition	3 ☐ Removal from	State	20b. Pla	ace of Dispo metery, cren	sition (Nam natory or ot	e of her plac			Date			- City or To	own, State
populities agost that a should be man important if item 27 Is marked other than any injury or other traumatic event, the money injury or other traumatic event.		4 ☐ Donation	5 Other (5	Specify)	State	Atla	ntic Cr			1	3-29-					Paryland
Depa Impo any i		21. Signature of Fi	uneral Service	NUV			Į Ž	Vitzke 5555 Tw	Funei in K	ral H nolls	omes. Road	Inc. Columbia	a, Ma	rylar	nd 2104	45
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To the company of the	Ź	29b. Signature and	title of certific	er m	0			29c	Licens	e numbe	87		29d. [	Date sign	ed (Month,	Day, Year)
) 🗸		30 Name and add	lress of persor	who completed cau	se of	Sulli	<sup>23a)</sup> (Type,	Print)	F	NA	ETIM	or e	H	NO Z	0212	2010
Sta Registr		31. Date filed (Mor	nth, Day, Year			rar's Signat		P								
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AMEND ITEM#10e, f, perfff, 6901, 3730/2010, ws
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A Month 0900 251 Kim Jonathan Lee Medical 4a. Facility Name (if not institution, give street and number 4b, City, Town, or Location of Death
Bull mure (1) 4c. County of Death Examiner Mai HIMORE Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min 08 II Year) 56 Months Director 214-68-2559 MD 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 10d. Inside City Limits Baltimore MD NA Yes 2 No 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? Surrey Squrr Funeral U.S.A. <del>21225</del> -Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Black 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Johns Hopkins College (1-4 or 5+) **2yrs+** Elementary/Seconday (0-12) Stationary Engineer 12th grade Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ <u>Mary Louise Cheeks</u> John Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Penhurst Ave, Baltimore, Md 21215 <u>Janice Lee-Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ₩☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King Memorial Park 3/29/10 Woodlawn, Md Sign tupf Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death flysicials disease or condition resulting in death) FOUND ( WORRED Medical Due to (or as a consequence Examiner GOWD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequ After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? hom has is 24a. Was an autopsy 2 🗹 No 1 Yes Be ( Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident 1 Yes 2 No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 L 3 L only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Belvedere Ave, Baltimore, Maryland 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Marylan	d / Department of Certificate of		lental Hygiene	UIU	09644
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Las	n La	wson		2. Date of Death Month Day	24,201	3. Time of Death
<i>,</i>	Examin Funeral Director	<u>.</u>	212-18-0201		Town	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birth	more place (State or Foreign
	Maryland		Usual Residence of Decedent  10a. State  10b. County  Ba/Hi		ty, Town or Location	aK			10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28e-f show r must be rudified at	Funeral Director	10e. Street and Number 6863 Parsons	Avenue	10f. Zip Cod	1207	10g. Cit	izen of What Col	untry?
	after or Ite	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	.S. 13. Was Oecedent of the Yes, specify C	of Hispanic Origin? (Sp cuban Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
9500-5121	within 72 ho ene. than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	ducation ide completed)  College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ne during most of work tired)	ing 16b. K	ind of Business/I	industry
Maryland 2	should be filed with nd Mental Hygiene i marked other tha imatic event, it etha	To Be C	Rufus Law.	son		18. Mother's Nam	e (First, Middle, Maiden	rd	
	s 1 and 2 if Health a item 27 lg other tree		19a. Informant's Name/Relationship  Vette Wade  20a. Method of Disposition	5/ster 20b. F	19b. Mailing Address (Str 6865 Par Place of Disposition (Name of cognetary, crematory or other,	sons ave	nue Guyn	1	MD 21207
Baltimore,	permit. Pages Department of Importent: If it eny injury or o once.		1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	y)	Park 22. Name and Ac	3.	ShAC. Green		re MI) ni Services D 21133
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the dear one cause on each line.	th. Do not enter the mode of	dying, such as cardiac		iwn in	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consec	quence of):	una co	incer		3 days
760, %	Ite be executed sysician and he burial-transit	cal Examiner	Sequentially list conditions, it any, reading to him adiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consecut.)  Due to (or as a consecut.)					
.O. Box 68	ath certifice ttending ph or use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1   Live birth 2   Feta 4   Pregnant at time of 9   Unknown	al death 3 ☐ Ectopic pregna			23d. Date of del Month	ivery Day Year
۵,	juires that the der n signed by the a ild be detached f	d by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause	given in Part I.		V	the cause of death?
l Records,	The law requir ate has been si page 2 should i	Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vita Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Other	th (Check only one)	- Fox (6)	7.
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Injury at Work?  1 Yes 2 No	ome 5 Residence 28d. Describe how inju		спу
Divis	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci			28f. Location (Street a City or Town, Stat	te)	
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifying P (Check only one) Medicel Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owiedge, death occurred at the ation and/or investigation, in a	ne time, date and place my opinion, death occu	, and due to the cause( rred at the time, date ar	<ul> <li>and manner as ad place, and due</li> </ul>	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	011 0-	29c. Lie	cense number	29d. D.	ate signed (Mont	th, Dey, Year)
)			- Koolda	Attendi	ng Do	005928	3 m	arch,	26,2010
	3	ate	30. Name and address of parson who	completed cause of death (Ite  Acido M.D.  32, Parietrar's Sign	8415 Be	llong La	ne, Ton	you !	26, 2010 MD 21204
. 36	Regist		WAR 30 9	man &	16.00				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 09645 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **9:32** Physician/ OI . Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** ltimore 0 0 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Carolina Yrs. **Director** ms 23a or 28a-f show must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Jown or Location Director 1 ☐ Yes 🌠 No timore 10g. Citizen of What Country? Funeral 0.5A 21244 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner al Hygiene. d other than "natural", or its event, the Medical Examine Armed Forces?
Yes 2 
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 No 21215-0036 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ TINGTON Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ND 20b. Place of Disposition (Name of cemetery, crematory or other place, Method of Disposition Date Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Dinas Mills Signature of Funeral Service Licensee 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 1001 A Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 No ate has been signed by the page 2 should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' ENSIDY 2 🗌 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: မ Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide work? 5 Pending 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1- critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100G State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2'0**"1**0 Leroy Nathan Lomax March 5:13A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NΑ Future Care Sandtown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 02-12-3 9. Birthplace (State or Foreign Country)
VA Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Hours 213-34-2252 78 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. Funeral 1100 Pennsylvania Avenue 21201 USA 14. Race - American Indian, Black, White, etcAfrican 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Lomax 1 ☐ Yes XXNo Specify: Specify: American 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Co. 2th Grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. Pearline Lomax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hatcher-Friend Pennsylvania Avenue Apt.#2-C Baltimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Circmation 3 Removal from State 03-29-10 Metro Crematory Catonsville, 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition neumonia WK Medical resulting in death) Due to (or as a consequence of): Examiner 5)5 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the attending physician and the for use as the burial-transit that the death certificate be executed Scloset that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy performed 1 Yes 2 No Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔏 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination alradous investigation, in my special control of the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Leseen MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) 501 Dolphin gistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 27, Day 2010 Year Physician/ 1:22 A M Sheau Ching Luh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Germantown 12923 Creamery Hill Drive 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days May 27, 1938 1 □ M 2 🛛 F China Director 219-02-1265 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 No Montgomery Germantown Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20874 United States 12923 Creamery Hill Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Asian Specify. 3 🗌 Widowed 4 🗎 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Taiwanese Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ya Wong မ Wen Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20009 1614 Q Street, NW, Apt. B, Washington, D.C. Yang Luh/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of March 29, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, In 300 W. Montgomery Avenue, Rockville, Maryland Million M01173 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma of the Pancreas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate and -transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ned by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Hypertension Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Type II the Hospital or Attending Physician: The law has autopsy performed? Yes 2 N 2 🗌 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 2 🗓 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

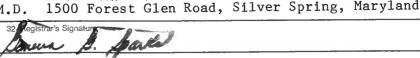
To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 X Natural 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

Robert H. Gerard, M.D. 31. Date filed (Month, Day, Year) MAR 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certifier



29c. License number

D0055522

29d. Date signed (Month, Day, Year)

March 29, 2010

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** INCENT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Seasons Hospice Randallstown Baltimore 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, May 25, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F 77 1932 Director 099-24-5651 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any hijury or other traumatic event. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 111 Grist Stone Way 21117 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give 1 ☐ Never Married 2 🔀 Married 1 ☐Yes 2 X No Specify: þ 3 Widowed 4 Divorced Year or Dates **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Lynch Gladys Brereton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Lynch lll Grist Stone Way Owings Mills, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 4/2/10 Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** nas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🕦 Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify, 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 ☐ Pending investigation eral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 04/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 28 20 TO 08:40A M **LERNER** HOWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS GENESIS SPA CREEK NURSING HOME 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Social Security Number 7. Age (In yrs. last birthday) Days 1 💢 M 2 □ 0470671925 Director 218-28-5483 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No ANNAPOLIS ANNE ARUNDEL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 194 MAIN STREET 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 🗆 Yes 2 🖁 No Specify: 3 Widowed 4 Divorced WHITE Year or Dates. 16b. Kind of Business Industry
GENERAL MERCHANDISE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) OWNER STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GREENBERG LERNER DOROTHY SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a If item 27 i 317 HALSEY ROAD, ANNAPOLIS, MD 21401 EUGENE M. LERNER / BROTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 03/29/2010 FINKSBURG, MD BETH JACOB CONG. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Oremia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): renal failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examin physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown s been signed by the should be detached P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) director Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ( funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one person who completed cause of death (Item 23a) (Type, Print) Pefense Hmy, Crofton MO 21114 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** LOUIS FRANCIS MASTRIANI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Regional Hospital George's aure aurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1[**X**M 2□ F Director 9/5/1925 New York, NY 132-05-5410 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 3160 Gracefield Road 20904 United States Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 😾 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Louis Francis Mastriani <u>Palma Rispoli</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Juniper St. NW Washington, DC 20012 Louis S. Mastriani / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/30/2010 | Riverdale, Maryland Riverdale Park 21. Signature of Funeral Service Micensee 22. Name and Address of Facility Pope Funeral Homes, P.A. pour 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Physician Days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician ar s the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical ast IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Accident 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death accurred. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D24035 March 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Silver Spring, MD 20904 Machado, MD 3110 Gracefield 31. Date filed (Month, Day, Year)

MAR 3 0 2010 32. Restrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 7:37pKathleen Marie March Montgomery Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 13 White Spruce Court Parkville Baltimore 8. Date of Birth (Month, Day March 22 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Year) 19<u>45</u> Maryland 1 □ M 2 🛛 F Months Hours Min. 212-50-5872 **Director** 65 Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 😾 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 13 White Spruce Court 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ò 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kenneth Gorrick Mary Kathleen Smallwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Childs/ Sister 13 White Spruce Court, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March<sup>Date</sup>29. 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours arer dear To the Funeral Director completed filled by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Box 68760 P.O. Division of Vital Records,

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

Medical

rson who completed cause of death MIB3a) (Type B75769 N. CHARLES

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D41406

STREE

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 23 Day 2010 ear Richard John McCarthy 4:50 pmM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours Min 1 🖵 M 2 🗆 F 380-44-8999 65 **Director** Sept Michigan Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MI Manistee Village of Copemish 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 49625 16766 Second Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 A Yes 2 No Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Completed White Year or Dates. 1962-63 er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Fruit Processing Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marker er traumatic e William McCarthy Elizabeth Shea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 16766 Second Street Nancy A. McCarthy permit. Page 1 and 2 Department of Heatth Important: If item 27 any injury or other th once, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/25/10 Alexandria, VA f Funeral Service Lices 22. Name and Address of Facility Terwilliger Funeral Home W Lou 9188 Osmo St. Kaleva, MI 49645 30a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ on disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Year Pregnant at time of death Day P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tyes 2 No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No Yes Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this completed filled in by the funeral 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Could not be hours after death uneral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier া Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

10v

2/0

7

McCarthy, Richard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Madiosn Leonard, MD

Suburban, Hospital, Bethesda, MD

31. Date filed (Month, Day, Year)

MAR 3 0 2010 State Registrar

29b. Signature and title of certifi

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and rtificate of Death		2011	09653
		-	Registrar  1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Death	. No. L	3. Time of Death
	Physicia		Elwood Jackson McDaniel		March 24	Day 2010 Year	6:37 PM
~ ,	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	<del>_</del>
-			Casey House	Rockville		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		577-32-1700   1 MM 2 L F   81 Yrs.  Usual Residence of Decedent		March 19	1929 Vir	ginia
	nd thow at	'n	10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	faryla Ba-f s tified	ect.	Maryland Montgomery Silver Sp	ring			1 🎇 Yes 2 □ No
	the N	ij	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cou	ntry?
	s 23a	era	3105 Adderley Court	20906		U.S.A.	
	death item ner m	Für	Armed Forces?	Was Decedent of Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	after I", or xamii	d b	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 3 Widowed 4 Divorced Vagren Datas	1 ☐ Yes 2 💹 No Specify:		Canalta	
8	atura cal E	Completed by Funeral Director	Tear or Dates.	dent's Usual Occupation	16	Sb. Kind of Business In	
215	n 72 h an "n Medi	ldm	(Specify only highest grade completed) (Give	kind of work done during most of wor OO NOT use retired)	king	3D. Killd of Busiless II	laustry
21215-0036	withir giene er th	ပ္ပို	12 College (1-4 of 3+)	mer & Operator		Plumbing &	Heating
Maryland	2 should be filed within 72 h and Mental Hygiene. ?7 is marked other than "! traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai		
yla	Men Men narke	F	William Vernon McDaniel	Fellie	Francis C	omer	
Mai	shoor hand		()	ng Address (Street and Number or Ru			
	and Healt tem 2		Lillian Elizabeth McDaniel 3105  20a. Method of Disposition 20b. Place of Disp	Adderley Ct., Si		ng, MD 209	
nor	age 1 ent of ht: If it y or c		1 N Burjal 2 Cremation 3 Removal from State cemetery, cre	matory or other place)		henandoah,	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility			VA
ñ	permir Depar Impor any ir		Januin 2 Minum	he Bradley Funera 87 E. Main St., I	l Home Lurav. VA	22835	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or conditiona _Endstage Parkinso	n!s			Onset and Death
and the	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):				
В	LAGITIME	Je.	Sequentially list conditions, b.				
	ed sit	dical Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury				
	xecut and al-trar	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	d				
376	ficate g phy as the						
k 687	endin use	an/N	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of deliv	very
Box	death he att ed for	Physician/Me		Other (specify)		Month	Day Year
P.O.	at the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	220 Did tobar	cco use contribute to t	he equipe of death?
σ,	es tha	Completed by	Recurrent Aspiration Pneumonia	anderlying oddoo green in raintii			bably 4 🗓 Unknown
rds	requir been should	ete	Medallent inspilation incamonia		24a. Was an		psy findings available
ecc	e law has ge 2 s	mp			autopsy	prior to co	mpletion of cause of
æ	n: Th fficate or, pa		25. Was case referred to medical	26. Place of Death (Che	performe	No 1 ☐ Yes	2 No
/ita	/sicia s cert direct	To Be	examiner? 1 ☐ Yes 2 【X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 Other (Specif	Hospice
Division of Vital Records,	ding Physician: The Is h. After this certificate ha funeral director, page		27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how		,, 1
on	endin eath. or: Aft he fur	fica	2 Accident Investigation	M 1 Yes 2 No			
VISI.	or Att fter de irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, S	et and Number or Rura State)	l Route Number,
۵	oital curs at eral D						
	Hosp 24 ho Fune eted f	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred	at the time, date and p	olace, and due to the ca	ause(s) and manner stated.
	o the	Σ	only one) 3 U Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License number		Luse(s) and manner as s	
	->-0		Mila Chiefres (12 18-E	(1)0698		March 25, 2	
	1 ,		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	11		
	QV			aster Mill Rd., I	Rockville,	MD 20855	
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ War Medical Examiner 4b. City, Town, or Location of Death Woodfo hmore last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Vew Jersey Director 0 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify "natural", 3 Widowed 4 Divorced lack Year or Dates 16a. Decedent's Usual Occupation Decedent's Education Give kind of work done during
life DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide မ Health and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zin 19a. Informant's Name/Relationship (Type, Print, 21207 enise Important: If item any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jarrison . Signaturerof Funeral Service Licensee aughn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Second or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury for use as the burial-tran יי שוש ירוש היו שופכנסו. Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performed? Yes 2 No or Attending Physician: The 1 🗌 Yes 2 🗌 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural  $5 \square$  Pending 1 🔲 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 25,2010 D0063657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste. 136 Bothmore, E. 3312 St., A. Watkins 200 31. Date filed (Month, Day, Year) 32. State

Registrar

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9

Certificate of Death

Reg. No.

**Physician** /Medical Examiner

38 2010 March

MD

9. Birthplace (State or Foreign

10d. Inside City Limits

1X Yes 2 □ No

**Funeral** 

Director

Director

Funeral

2

Completed

Be

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death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine and.

Baltimore, Maryland 21215-0036

28a-f sh notified a or "natural", or items 23a

**Physician** 

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Physician/Medical attending properties for use as ed by the a detached f <u>ک</u> Completed cate has t this certific al director, Be Medical Certification: To After death. 24 hours after death.

• Funeral Director: A

• Filed in by the fi

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Randolph Muse 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore Loch Raven Center 8. Date of Birth (Month, Day, Ye 9 / 15 / 40 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) Days Hours 216-36-8604 **X**☐ M 2☐ F 69 Usual Residence of Decedent 10b. County N/A 10c. City, Town or Location Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21206 4106 St. Thomas Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status African 1 Never Married 2 Married 1 ☐ Yes 2 ☐ ¥No Specify: 3 ☐ Widowed 4 ☑ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Steel Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Mary Muse 19a. Informant's Name/Relationship (Type. Print)
Randolese Mills/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 St. Thomas Ave, Baltimore, MD 21206 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Ardent Crematory 3/30/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuher II Service Licensee 22. Name and Address of FacilityHari P. Close F.Svs.PA 5126 Belair Rd,Balt.,MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

3 ☐ Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

24a. Was an autopsy performe 1☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed

Hospital:

11 A Rockville NO 20850 31. Date filed (Month, Day,

State Registrar

within 2 the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ William Peter Murphy 2010 8:15a 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harmony Hall Columbia Howard ocial Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Months sept 11 Country) 130-22-7290 78 T931 Scotland Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Howard Columbia 1 🗌 Yes 2 💢 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 6336 Cedar Lane USA 21044 12. Was Decedent Ever in U.S. 1951 – within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? 1951

1 1 Yes 2 No 1954

If Yes, Give Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify. Specify: White "natural", Completed 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Murphy Alice Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3149 Catrina Ln., Annapolis, MD , 21784 Kimberlee Canavan ( Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calverton, NY Calverton Nat. Cem. 3-30-10 22. Name and Address of Facility Haight Funeral Home & Chapel . Signature of Funeral Service Licenses Daig Harghet I P.O. Box 195 Sykesville, MD 21784 erbes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy performed? Ves 2 X No 24a, Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of completing and/or inventioning in my principle. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 3 0 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09657 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Herman Mink  $20\overset{\text{Year}}{10}$ 8:36p March 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7412 Second Avenue Carroll Svkesville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 TA 7. Age (In vrs. last hirthday) Months Days Aug 21 1926 227-28-0294 1X□M2□F 83 Yrs VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7412 Second Avenue 21784 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was becedent Ever in U.S.
Armed Forces?
1 Xes 2 No WWII
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 Yes X No Specify Specify: white 3 ☐XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) electric master electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph T. Mink Milda Sommons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Thompson (daughter) 7610 Boulder Dr., Sykesville, MD 21784 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Evergreen Memorial 3 - 27 - 10Finksburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Hain Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final

Physician/ Medical **Examiner** 

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page 2 s

funeral director,

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within 24 hours a

Division of Vital Records, P.O. Box 68760

Department of Important: If it any injury or o once.

Physician/

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**Examiner** 

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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	cause. Enter Underlying Cause (Disease or iinjury that initiated events	Cue to (or as a consequence of)							
alcal EX	resulting in death) Last	Due to (or as a consequence of):							
Ilysiciali/Ine	F FBMALE:   23b. Was decedent pregnant   in the past 12 months?   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Other (specify)   Month								
red by FI									
	Atrial 1-	Brillation		24a. Was an autopsy performed?	death?	topsy finding completion of	gs available of cause of		
ט	25. Was case referred to medical examiner?		26. Place of Death (Check of	nly one)					
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	Other: 4 Nursing Hom	e 5 Residence	6 Other (Spec	ify)			
ilcate.	27. Manner of Death  1 ArNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at 28 work? 1 ☐ Yes 2 ☐ No	3d. Describe how inju	Describe how injury occurred				
T Cel	4 Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office 28	Bf. Location (Street a. City or Town, State		ural Route Number,			
SIDAIN	(Check 2 Medical Examin	ician: To the best of my knowledge, death occured inter: On the basis of examination and/or investigation, is Practioner: To the best of my knowledge, death occ	n my opinion, death occurred at th	ne time, date and plac	e, and due to the	cause(s) and	manner stated.		

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29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month

came 30 20

DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

380

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 20<u>10</u> **Physician** ELIZA JANE SILVEUS MAIER MAR 26 11:00 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours 87 1922 Pennsylvania Director 354**-**16**-**3270 April Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Midical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8708 Preston Place 20815 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Volunteer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil h and Mental H 7 is marked ot Be 2 John T. Silveus Gladys Meek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. of Health Alfred J. Maier/Husband 8708 Preston Place, Chevy Chase, Maryland 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 Removal from State April 1, 2010 | Waynesburg, Pennsylvania Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Greenemount permit. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licenses Haron haus M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CEREBRAL VASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician at the burial Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö the a 1 ☐ Yes 2 🕱 No 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? N autopsy page 2 performed' this certificate 1 ☐ Yes 2 StNo 1 XYes 2 □ No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TX No ٩ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔽 Natural 5 Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 0116020509 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL JEFFREY J. LEVINE LTMC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

10-02322
Thomas McDonough

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	Legible.	1 1965
	State of Maryland / Department of Fleatin and Mental Hygiene	1 0 1 C	
ate r	Certificate of Death	Reg. No.	

		1- For State Ce Registrar	rtificate of Death	Re	eg. No.	
Physici		Decedent's Name (First, Middle,Last)		Date of Death     Month	h	3. Time of Death
edical Exami	iner	Thomas F. McDonough		March 22,	Day Year 2010	1621 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Deatl	1
		1715 Perryville Road	Perryville		Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. )	last birthday) If Under 1 Year If Under 24H  Months Days Hours M		th(MM/DD/YYYY) 9. Bir Co	thplace (State or Foreign ountry)
Director		173-38-0509	Yrs. Violitis Days Flours IVI	Feb. 1	.8, 1951	PA
,		Usual Residence of Decedent				
w any		10a. State 10b. County 10c. City	, Town or Location			10d. Inside City Limits
land -f sho	tor	MD Cecil	Perryville			1 Yes 2 X No
Mary r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
h the		1715 Perryville Road	21903		USA	
death with the Maryland or items 23a or 28a-f show must be notified at once,	Funeral	11. Manital Status 1 Never Married	<ul> <li>.S.   13. Was Decedent of Hispanic Origin? ( \$\frac{1}{2}\$ If Yes, specify Cuban, Mexican, Puerl</li> </ul>		14. Race - Amer White, etc.	ican Indian, Black,
or it	Fur	1 Yes 2 📉 No				TTL d as a
s afte rraf",	by	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Consultation of the Consul	-77-	White
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examinst	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/	industry
36 iin 72 han dical	ple	12	Beverage Manager		Food Se	rvice
5-0036 lled within 7 Hygiene. I other than	E O	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		1 1 1 1 1
215 e file tal Hy ked o	Be	Francis A. McDonough	Agnes		,	
Dre, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Higene. If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once	ToE	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or		ber, City or Town, State	e, Zip Code)
MD d 2 sho lth and lth and n 27 is numati		Frank McDaniels	15 Patton Road, Anny	ville, PA	17003	
e, MC I and 2 s Health an item 27			Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		Dullar 2 XCremation 3 Nemovarilom state		3/10	Homed above	D.A
nit. Partme		4 Donation 5 Other Specify: HOC 21. Signature of Funeral Service Licensee	22. Name and Address of Facility 118	3/10 ]	Harrisburg	3, PA
Balt permit. Depart Import injury		Stephen M. Jenk	Eline Funeral Home	. Reister	erstown Ko.	ad 21136
Physician		23a. Part I. Enter the disease, or complications that caused the death				Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Cardiova:	scular Disease			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of				
		Sequentially list conditions, b				
	Examine	if any, leading to immediate Due to (or as a consequence or cause. Enter Underlying Cause	τ):			
= =	хап	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or	f):			
cecuted and transit	ᇤ	d				
ial ar	edical	UNPENDED				
68760, certificate bo nding physic se as the bur	≥	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery	
leath certifi e attending for use as t		past 12 months?	2 Fetal death 3 Ectopic pregreath 5 Other (Specify)	nancy	Month I	Day Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
O. B nat the de d by the		Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
es the	ğ	Emphysema; Chronic Alcoholism		1 Yes	2 No 3 Prob	ably 4 Unknown
require	Completed		***	24a. Was a		topsy findings available
e law e has	티			autops	ned? death?	completion of cause of
of Vital Records, ng Physician: The law requir Witer this certificate has been someral director, page 2 should be		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 Y	s 2 No
ivision of Vital I or Attending Physician: after death. Director: After this certifi in by the funeral director,	a	examiner? Hospital: 4 Insertions 2	Other:		Residence 6 🗸 Other	: Scene
of Ving Phy	밁	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
on on ath.	톊	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division rate of a strength of	fica	2 Accident Investigation 3 Suiride 6 Could not be	ome, farm, street, factory, office building, etc.	28f. Location (St	treet and Number or Ru	ral Route Number, City
Divisopital or A hours after meral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ate)	
Hospital 24 hours Funeral tely filled	Ca C	29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death occurred at the time, date and place, an	d due to the cause	e(s) and manner as state	ed.
To the within 7 To the complet	ig ig	one) 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occurred	at the time, date a	and place, and due to the	e cause(s)
5 3 6 3	Medi	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
		( X Color NO	O.C.M.E.		March 23, 2010	
ا د		30. Name and address of person who completed cause of death (Item	23a)			
		Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 213	201		
	tate		ire A Barkol			
Regis	_	MAKOU / William / Marsura				

		1 - State Registrar	tate of Maryland		artment of H tificate of D			ene g. No.		
Physic /Medi		1. Decedent's Name (First, Middle, Last)		Mar	shall		2. Date of Death	26 2011	1041 AM	
Exami	ner	4a. Facility Name (If not institution, give street The Johns Hopkins Hosp			4b. City, Town, or <b>Baltimore</b>			4c. County of Dea	ıth	
Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M	2 X F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 9–29–1	(eer) 9. Bit Co	rthplace (State or Foreign ountry) RGINIA	
e Maryland 8a-f show tified at	Director	Usual Residence of Decedent  10a. State  10b. County  VIRGINIA HANOVER		Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
3a or 2		10e. Street and Number 14027 WINSTON ESTAT	ES LANE		10f. Zip-Code 23005		10g. Citizen of What Country?			
hours after death	by Funeral	11. Marital Status  1 Never Married 2 Married	Vas Decedent Ever in U.S.  Irmed Forces?  Yes 2X No  Yes, Give ear or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2√2 No		pecify Yes or No- Rican, etc.)	USA  14. Race - Ame Black, White Specify: B1	te, etc.	
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2 should be and Mentals marked aumatic er	2	WILLIAM DABNEY WINS  19a. Informant's Name/Relationship (Type. P		19h Mailin	a Address (Street e		E BRADLE	Y City or Town, State,	Zin Code)	
Tand 2 sho Tand 2 sho Health and tem 27 ls ma		CHARLMAIN JOHNSON(D.	1					TENN 370	, ,	
Pages 1: nent of He nt: If iten		20a. Method of Disposition 1	val from State cen	netery, crem	sition (Name of actory or other place		-2010	Oc. Location - City or		
per nit. Pages Leyartment of Important: If if any injury or one.		4 □ Donation	ONATHAN D. H	STON I IBNE₩	FAMILY CE Name and Address	METERY s of FacilityHEN	RY W. DAH	SHLAND, VI BNEY FÛNEF	RGINIA RAL HOME	
		23a. Part 1 Eyler the disease, or complication	ns that caused the death	/ P	.O. BOX 5	28 ASHLA	ND, VIRGI	INIA 23005	Approximate	
Physician / Medical Examiner		shook of heart failure. List only one cau Immedia e Gause (Final disease or condition resulting death)	Acute myo  Due to (or as a consequent	cardia					Interval Between Onset and Death	
ficate be executed physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, bear y to innediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b	Due to (or as a consequent	nes oi):		· ·				
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysician/Med	F FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   1   Yes   2   No   No							livery Day Year	
w requires that the been signed by	by P	Part II. Other significant conditions contribu	ting to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did toba		co use contribute to the cause of death?	
The law rec ate has beer page 2 sho	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
slclan; certific director,	Be	25. Was case referred to medical examiner? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	tal: 1 <b>X</b> inpatient 2 ☐ EF	R/Outpatient	3 DOA Other		h (Check only one)	ce 6 🗆 Other (Spe	oite	
ding Phy th.: After this e funeral o	ation: To		1	8b. Time of Injury	28c. Injury Work?	at	28d. Describe how			
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has be completely tilled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	e. Place of injury - At home building, etc. (Specify)				City or Town,			
ne Hospit n 24 hour ne Funera pletely tille	edical (	2 Medical Examiner:	To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	and due to the cau rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
To the complete of the complet	M	29b. Signature and title of certifier  M.D.			29c. License	number S - CCO		Date signed (Mont		
		30. Name and address of person who comple	eted cause of death (Item 2	23a) (Type, F	Print)	600			ore, MD, 21287	
Sta	ate	31. Date filed ARR 300 2010	32. Registrar's Signature	has	V	300		, <b>-</b>	,, בובטו	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29 Day 2010 Nelson Mary Heavel 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore 2525 Pot Spring Road Apt. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Funeral 8. Date of Birth Days 1 M 2 F Months Hours 216-16-6517 87 04/23/1922 Baltimore, MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21093 2525 Pot Spring Road Apt. 702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc 1 Never Married 2 X Married ģ :h 29, 2010 ToD 7:50 AM Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homeowner Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Winifred Rilev Charles Heavel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2525 Pot Spring Road Apt. 702, Timonium MD 21093 Robert Nelson/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Episc.Ch.Cem.: 04/01/2010 Long Green, MD 4 Donation Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funera March Ruck Towson Funeral Home, INc. 1050 York Road Part 1. Ever the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Nelson Examine if any, leading to immediate cause. Error Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Other (specify) Pregnant at time of death ed by the a detached i 9 | Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law autopsy certificate Yes 2 N Be 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? 2 No Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other (Specify)} \) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral to 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 10 V 120 SISTER PIERRE DR STIDI Ock MA 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:15 A M Sophie Helen Olszewski 2010 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2725 Carsins Run Road Harford Aberdeen 8. Date of Birth (Month, Day, Year) 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M M F Months Davs Hours Min Pennsylvania 184-12-1529 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10h County 10c. City. Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Evaning must be notified at 1 ☐ Yes 2 No Director Maryland | Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2725 Carsins Run Road 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No "natural", or Specify 2 3 N Widowed 4 □ Divorced White Completed d other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 Is marked other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Frances (nmn) Olsiefski Stanley (nmn) Katusz Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra once. JoAnn Stalev / Daughter 2725 Carsins Run Road, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4-1-10 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dA 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 10 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Acure 1/2/ 10 PATI Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 0201Ar 1 Yes 2 No 3 Probably 4 Unknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To s after death.

I Director: After this of in by the funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a completely filled 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the I Fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66342 who completed cause of death (Item 23a) (Type, Print) K. Patel, M.D. 30. Name and address of person Rd. 1000 21016 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

09663

		-	For State Registrar	,	Cen	tificate of L	Death	R	leg. No.	
	Physicia	,	1. Decedent's Name (First, Middle, Las					2. Date of Deat		3. Time of Death
	Medic	al .		atsy D	Ors	sino	I Total of Death	March	28, 2010 Year 4c. County of Death	8:08 P™
	Examin	er	4a. Facility Name <i>(if not institution, give</i> Stella Mari				Location of Death		Baltin	nore
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g. Birth	place (State or Foreign
	Director		220-40-0168 1 Usual Residence of Decedent	□ M 2 🕅 F 66	Yrs.	Western Taylor	110010	8/28/19	43 Mary	land
	and show	. 1	10a. State 10b. County	10c. City,	Town or Loc	ation				0d. Inside City Limits
	Maryla 28a-f	Director	Florida Lake		Lady I					1 ☐ Yes 2 💢 No
	h the		10e. Street and Number			10f. Zip Code	1450		10g. Citizen of What Cour	ntry?
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural" are must be notified at raumatic event, the Medical Examiner must be notified at	Funeral	2022 San Leona	rdo Way  12. Was Decedent Ever in U.S.	13. V	as Decedent of H	2159 ispanic Origin? (Spe	ecify Yes or No-	U.S.A.	can Indian,
و بـ	er de: or ite miner	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo	l If	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
8:08 p.m. 21215-0036	urs aff tural", al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		Yes 2 No				lite
15-	72 ho n "nai Aedica	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give k	ent's Usual Occup ind of work done ( O NOT use retired)	ation during most of work	ing	16b. Kind of Business In Baltimore Fe	
8:08 21215	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)		gage Bank	cer		Savings & La	
	filed tal Hyg	To Be	17. Father's Name (First, Middle, Last)		`		18. Mother's Nam			
2010 Irylan	uld be if Ment marke natic	٦	John 19a. Informant's Name/Relationship (7)	<u>Hetzel</u>	401 14 7	A 1.1 (Ot	Rut		Boyer City or Town, State, Zip	Code
- (0	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Orlando Orsino, J		ı				Lake, FLoric	
28 <b>,</b> re, M	1 and 2 of Health item 27 other tr		20a. Method of Disposition	20b. Pl	ace of Disno	sition (Name of natory or other place		Date	20c. Location - City or To	
MARCH saltimo	Page 1 ament of Pant: If its ury or of		1 Burial 2 \ Cremation 3 \ \ \ Donation 5 \ Other (Special Control Con	(fy) Hill	Ltop Se	ervice <u>Co</u>	orp. 3-30-	-2010	Towson Ma	aryland
MARCH 28 Baltimore,	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licen	I Rush		. Name and Addre		uck Tows owson, M	on Funeral l aryland 21	Home, Inc. 204
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	flications that caused the death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician/		Immediate Cause (Final disease or condition	a BREAST CANCE	R					Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequent	ence of):					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c						
	ificate be executed by physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	ence or):					
8760	cate b	Medical		d						
Ó	certifi anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy Ideath 3	Ectopic pregnan	cy		23d. Date of deliv	
Box	death the att	Physician/	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at time of d g ☐ Unknown	eath 5	Other (specify) _			Month	Day Year
00	nat the ed by 1 detach		Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
ORSINO ords, P.C	uires t n sign ald be	ed by						1 🗆 `	Yes 2 ☐ No 3 ☐ Pro	obably 4 🛣 Unknown
7.	as bee 2 shou	Completed						24a. Was a	an 24b. Were auto prior to co	ppsy findings available empletion of cause of
PATSY tal Rec	The la	Con						1 🗆 Yes	rmed? death? 2 X No 1 ☐ Yes	2 🗆 No
PA Ital	sician; certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	FB/0: ++	CHI	Place of Death (Chec		lence 6 <b>X</b> Other (Specif	HOSPICE
	g Physer this ieral di	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury		ry at		ow injury occurred	y/ HODI 101
on	eath. or: Aft: the fur	fical	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not	on		M 1 🗆	Yes 2 No			
Division of	or Att after d Direct in by	Certificate:	4 Homicide determined		me, farm, str	eet, factory, office		28f. Location (S City or Tow	street and Number or Rura rn, State)	ai Houte Number,
Q	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled in the basis of examination	edge, death	occured at the tim	e, date and place, a	nd due to the car	use(s) and manner as stat	ed.
	the Ho nin 24 the Fu	Mec	only one) 3 X Certifying Nu	rse Practioner: To the best of my	knowledge,	death occurred at t	he time, date and pla	ce, and due to the	e cause(s) and manner as s	tated.
	Von Con		29b. Signature and title of certifier	Marchina	+P	29c. Licens	67(-29		29d. Date signed (Month,	VAy, rear)
			30. Name and address of person who	completed aluse of death (Item	23a) (Type, F	Print)	11001		Olvilac	10
i-	1		JENNIFER HAUF, C	RNB / 2300 DULAN	VEY VA	LLEY RD.	TIMONIU	M. MD 21	.093	
	Sta Registr		31. Date filed (Month, Day, Year) NAR 3 0 2010	32. Registrar' Signat	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09664 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -UCILLE . P. 5:55 PM 6,2010 Marc OGLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jennifer Lane ARFORD ABERDEEN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 9 147 4 924 Maryland 219-18-0686 85 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No Aberdeen Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any njury or other traumatic event, the Medical Examiner must be, any njury or other traumatic event, the Medical Examiner must be. Funeral 21001 USA 627 Jennifer Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. White Specify: No specification No specification No specification No specification No specification No specification No specif Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 □ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances C. Finkernagel Wilton Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Orndoff Dr, Clearbrook, VA 22624 Trish Bierlich / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Harford Mem. Gardens 3/31/2010 Aberdeen 4 Donation 5 Other (Specify) <sup>22. Name and Address of Facility</sup>
Tarring-Cargo Funeral Home, P.
333 S. Parke St, Aberdeen, MD 21, Signatury P·A 1D 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) ⊾ Medical Due to (or as a consequence of Examiner -54ears PULMONARY DISEASE Sequentially list conditions it any, leading to inimediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a ld be detached for a Unknown 9 Unknown N/A P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILATION ATRIAL 1 Yes 2 No 3 Dobably 4 Unknown Records, Completed director, page 2 should ANAEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform POOR certificate MOBILITY 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) \( \text{HCSPICE} \) Hospital: ည 1 🗌 Yes 2 🕡 🛶 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending N/A 1 ☐ Yes 2 ☐ No Accident Suicide Investigation N/A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sood 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

ALMOT

ABERDEEN MD2100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03-24-2018 Helen Pacifico 1651 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) PA 1 □ M 2 🕅 F Months Hours 1 Month 1 Day 1931 58 208-42-2747 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Harford Abingdon 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 439 Abbey Circle USA 21009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force giene. Ier than "natural", or i Black, White, etc 1  $\square$  Never Married 2 X Married þ ☐ Yes 2 🕅 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 School Teacher 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other th Harford Cty PublicSch Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Manik Helen (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Pacifico (husband) 439 Abbey Cir Abingdon, MD 21009 permit. Page 1 and 2 Department of Healt Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Mem. Gardens 03-29-2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signati re of Fineral Service I MacPhail Rd BleAir, MD 21014 Inc 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, nKnown Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, hearing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consecuence of physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thrombocytopenia 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown ver cirrhosis Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Cholecustitis ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: မ 1 Yes 2 No Other: 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No Investigation Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined Medical within 24 hou

To the Fune

completed file 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Inamosan M.D

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

<b>1 - State</b> Registrar  Certificate of Death Reg. No.	0010 0000
1. Decedent's Name (First, Middle, Last)  2. Date of Death	3. Time of Death
Physician/ Medical  BEULAH A. PASCHALL  Month March 26	2010 8:27 A M
	c. County of Death
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
Director 578-26-0713 1 M 2 X F 92 Yrs. Months Days Hours Min. 0 1 702/1918	Staunton, VA
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location Clinton 10c. City, Town or Location Clinton 10c. City, Town or Location 10c. City, Town or	1 ☒ Yes 2 ☐ No
10e. Street and Number 10f. Zip Code 10g. Ci	tizen of What Country?
7029 Groveton Drive 20735  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA
Armed Forces?	14. Race - American Indian, Black, White, etc.  Specify: Black
15. Decedent's Education 16a. Decedent's Usual Occupation 16b. K (Give kind of work done during most of working	Kind of Business Industry
College (1-4 or 5+)  Nurse  Gov  17. Father's Name (First, Middle, Last)	vernment
The part of the pa	Surname)
Essex Stewart    Part	
20c. Lo Date 20c.	ocation - City or Town, State dover, Maryland
23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Medical class (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Constant Ark 1714 M1 A  Due to (or as a consequence of):	
Due to (or as a consequence of):	
Patronomy of the control of the cont	
icate be e. graphysician is the buring the buring in the buring in the puring in the p	
20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Your conditions contributing to death but not resulting in the underlying cause given in Part I.    See a part of the part of	23d. Date of delivery  Month Day Year
Sylva a distribution of the state of the sta	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco u	use contribute to the cause of death?
	No 3 Probably 4 Onknown
To County of the control of the county of th	24b. Were autopsy findings available prior to completion of cause of death?
To be a separate to medical examiner?	o 1 🗆 Yes 2 🗆 No
Hospital: 1 Inpatient 2 PR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	Cother (Specify)
Describe how injury at work?  28d. Describe how injury at work?	y occurred
28d. Describe how injury at work?  1 Academ investigation 3 Suicide 4 Homicide Homicide Homicide Homicide   28d. Date of Injury - At home, farm, street, factory, office building, etc. (Specify)   28b. Time of injury at work?  28d. Describe how injury (Month, Day, Year)   28b. Time of injury at work?  1 Yes 2 No   28d. Describe how injury work?  28d. Describe how injury at work?	d Number or Rural Route Number,
S to the second	4
Cause (Disease or injury that initiated events break that	, and due to the cause(s) and manner stated.
29b. Signature and title of certifier 29c. License number 29d. Date 20d. Dat	te signed (Month, Day, Year) S HG - (O
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  COLL TWO COLL TO SULLY ROLL TO MICE TO THE PROPERTY OF T	0735
31 Pate filed Atlanth Dev Year	
State Registrar  31. Date filed (1/2011) Party (2012)  Registrar's Sit at receivers Sit at	

HIN TITEOUTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0966 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24<sup>y</sup> Paul R. Pelfrey March 2010 12:00pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F 527-37-0872 51 Hours Nov. 20 ear 1958 Country) Director CA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗆 Yes 2 🗖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7102 Gough Street 21224 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Manager Lockheed Martin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Alex Pelfrey Vivian Kitchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Staylor /friend 3401 Butler Street Pitt. PA 15201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State competery, crematory or other place)
Holly Hill Cemetery 3/27/10 Baltimore MD 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD 21. Signature of Fur eya 3 rvice Licensee á Connelly Funeral Home of Essex inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death shock, or heart failure, List or Immediate Cause (Final ACUTE NUE

Due to (or as a consequence of): MUELOGENOUS Physician/ disease or condition resulting in death) MONTHS Medical Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24a. Was an 24b. Were autopsy findings available ate has t prior to completion of cause of death?

1 Yes 2 No autopsy within 24 hours after death.

To the Funeral Director: After this certificate the completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) #OSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 MARCH 24, 2010

State Registrar 31. Date filed (Month, Day, Year)

MAR 30

DHMH 17 Rev 7/2009

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32 Registrar's Signatur

NCHAPLES ST, 84172 4105 BAITIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Plea nend 19a-b, per	i <b>se Type or Pri</b> <b>Ph G902 4/6/</b> State of Ma	<b>nt in B</b> 10 TT aryland	lack Ir I / Depa	ndelib artmer	<b>le Ink</b> nt of H	<b>c. Ens</b> lealth a	<b>ure A</b> and M	<b>II Copie</b> Iental Hy	s A	re Legi ne	ible.		
			State Registrar			Cer	tificat	e of D	eath			Reg.	No. 2 1	10	ng	568
	Physicia	ın/	1. Decedent's Name (First, Middle	_							2. Date of De Month	eath	Day	Year	3. Time of	Death
	Medic		Doris	E. Pac	e						March	28,	<sup>Day</sup> 2010	Icai	2:29	a <sup>M</sup>
	Examir	er	4a. Facility Name (if not institution Gilchri  5. Social Security Number	st Hospice			7	l'owso					4c. County	Balt	imore	
	Funeral Director		218–18–3082 Usual Residence of Decedent	4 🗆 14 0 🗆 🖻	e (In yrs. las 86	t birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min,	8. Date of Bi (Month, Da April		1923	9. Birth; Coun	olace (State o try) MD	
	Aaryland 8a-f show tified at	Director	10a. State 10b. County		10c. City,	Town or Loc		ltimo	re					1	0d. Inside Ci	ty Limits
	s 23a or 2 ust be no	Funeral Di	10e. Street and Number 3737 Cl	arks Lane Un	it 30	9	10f. Zi <sub>l</sub>	Code 2	1215			10g.	. Citizen of W	/hat Cour	ntry?	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4X Divorced	If Von Civo		If	Yes, spe	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe ı, Puerto I	cify Yes or No- Rican, etc.)			k, White,		
5-0	2 hou "natu edical	plet		nt's Education est grade completed)		16a. Deced	lent's Usu	al Occupa	ition uring most	of workii	na	16b	o. Kind of Bu	siness Ind	dustry	
12121	d within 7 lygiene. <b>ther than</b> nt, the Ma	Be Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	Speci	O NOT us	retired) Pione	er				Relig		5	
Maryland 21215-0036	uld be file Mental H narked of	To B	17. Father's Name (First, Middle, I Reginal	d Blackwell					18. Mothe	er's Name Eth	e (First, Middle, nel Me	, Maid ade	,			
	and 2 shou Health and em 27 is n her traun		19a. Informant's Name/Relations Patria Patricia A. H	nip (Type, Print) Iill / Daught		3939	Cla	ks L		¥ 309	Route Number	imo	ore, M	D 21:	215	
Baltimore,	t. Page 1 attent of herent of herent of herent if ite		20a. Method of Disposition  1	Specify)	Fin	ce of Dispos netery, crem al Joi	natory or o	ther place		_	<sup>2</sup> 2010		Voodbi			
Bal	permir Depar Impor any in		21. Signature of Funeral Service I	icenses brotta Ma	rshal Skol	22.	Mars	land	s of Facility Cren 413	natio	n Serv	ice M	s 2120	3		
Physician/ Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition resulting in death)					consequer	nce of):	r the mod	e of dying	such as	cardiac o			rage	-	Approximate Interval Betwood Onset and D	ween
	ate be executed bhysician and the burial-transit	edical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  Due to (or as a consequence of):													
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal c	death 3 🗌	Ectopic   Other <i>(sp</i>	pregnancy pecify)	′				23d. Date Mon		•	'ear
ds, P.O.	v requires that the de been signed by the should be detached	ed by P	Part II. Other significant condition	ins contributing to death but			nderlying	cause give	en in Part I	•	23e. Did t		12		e cause of de	- 1
Division of Vital Records,	<b>sician:</b> The law rec certificate has bee lirector, page 2 sho	Somple									24a. Was auto perfo 1 \(\sum \) Yes	psy ormed	pr ? de		osy findings a mpletion of ca	
<u>a</u>	sian: ertific ctor,	Be (	25. Was case referred to medical examiner?						ce of Deat	h (Check						
⋝	hysic this co	ပ္	1 ☐ Yes 2 Ø No	Hospital:			t 3 □ D	Other DA	". 4 □ Nu	rsing Hor	ne 5 🗆 Resid	dence	6 Other	(Specify)	HORE	sice
on of	I or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	Certificate:	27. Manner of Death  Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation	Year)	3b. Time of injury	M 2	8c. Injury work? 1 🗌 Y			8d. Describe h	now in	jury occurred	d		
Divis	ital or Attendi urs after death. ral Director: A lled in by the f		4 Homicide determ			e, farm, stre	et, factory	, office		2		on (Street and Number or Rural Route Number, Town, State)				
	To the Hospital or within 24 hours after To the Funeral Dir completed filled in	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	amination a	nd/or investi	gation, in	mv opinion	i, death oc	curred at t	the time, date a	and pla	ace, and due t	to the cau	se(s) and man	nner stated.
	vitl To		29b. Signature and title of certifier	Trulo	C.P.	NP	290	License	number	0	,		Date signed			)
1	V		30 Name and address of person v	who completed cause of de	ath (Item 20	3a) (Type, Pr		50	100	م در	Rive		Town	en 1	M() 9	1204
	Stat Registra	e ir	31. Date filed (Month, Day, Year) NAR 3 0 2010	32. Registral	's Signatur	ale	0		, -		3100					

10-02314 Paul Peranio Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Peranio	1- For State Registrar	epartment of Health and Mental Hy Certificate of Death	rgiene Reg. No. 2010 1956				
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)     Paul Peranio		2. Date of Death Month Day Year March 22, 2010  3. Time of Death 1456 hrs				
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Sinai Hospital  4c. County of Death  Baltimore						
Funeral Director		yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD				
any	Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Location	10d. Inside City Limits				
<b>*</b> .	MD NA F	Baltimore	1X Yes 2 No				
ith the Maryland 23a or 28a-f sho botified at ouce. al Director	10e. Street and Number	10f. Zip Code 21209	10g. Citizen of What Country?  USA				
ms 23a be noti	2420 West Rogers Avenue  11. Marital Status  1. Was Decedent Ever Armed Forces?		ecify Yes or No- 14. Race - American Indian, Black,				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes 2 2 1		Specif American				
hours after a natural"  Examine	15. Decedent's Education (Specify only highest grade complete	ad) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retire	ork done 16b. Kind of Business/Industry				
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12)  None  NA	None	None				
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name Joyce	(First, Middle, Maiden Surname) Brown				
212 hould be and Menta is mark ritic even	Paul Peranio  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or Re	ural Route Number, City or Town, State, Zip Code) $21209$				
e, MD and 2 sh Health an item 27 i		20h Place of Disposition (Name of cemetery	Avenue Baltimore, MD.  Date   20c. Location - City or Town, State				
Baltimore, permit. Pages lar Department of Hei Injuryor other reinjury or other rein	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Metro Crematory 03	-26-10 Catonsville, MD				
Baltimo permit. Page Department of Important: Injury or ott	21. Signature of Funeral Service (Tensee	22. Name and Address of Facility Wy	lie Funeral Home P.A. reet Baltimore, MD 21217				
Physician	23a. Part I. Enter the disease, or complications that caused the difailure. List only one cause on each line.		respiratory arrest, shock, or heart Approximate Interval Between Onset and				
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Complication  Due to (or as a consequent	ons of Maignant Tumor	Death				
<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequen	nce of):					
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent						
be executed sician and urial - transit	d	2700/ 0 25 10					
be e burrial	IF FEMALE:  AMENDED 23a,  23c. If yes, outcome of	27 per me g906 8-25-10 vt	23d. Date of delivery				
Box 6876( death certificate the attending phy af for use as the b nysician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of	2 Fetal death 3 Ectopic pregnar of death 5 Other (Specify)	Month Day Year				
<b>©</b> 5 € 2 <b>©</b>	Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but r		23e. Did tobacco use contribute to the cause of death?				
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rs after death.  at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P		, , , , , , , , , , , , , , , , , , , ,	1 Yes 2 No 3 Probably 4 Unknown				
Records, The law require, ficate has been sig., page 2 should be Completed			24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?				
tal Rectinan: The lectinate lector, page	25. Was case referred to medical	26.Place of Death (Check o	1 ✓ Yes 2 No 1 ✓ Yes 2 No				
F Vital I Physician: r this certifi al director,	Tes 2 No	2 R/Outpatient 3 DOA Other Nursing					
ion of Vending Physeath.  the funeral ation: Talent of Vending Physeath.	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
Division o ospital or Attending hours after death. Inneral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Could not be	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospita 24 hours Funeral etely fille	Homicide  29a. Certifier  (Check only 1 Certifying Physician: To the best of my known only 1 Certifying Physician: To the best of my	wledge, death occurred at the time, date and place, and d					
To the Howithin 24 For the Funcompletely	one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	tion and/or investigation, in my opinion, death occurred at  29c. License number	the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)				
	0-m2-m	O.C.M.E.	March 23, 2010				
or park	30. Name and address of person who completed cause of death ( Donna M. Vincenti, MD Assistant Medical E		D 21201				
V State Registrar	31. Date filed (Moltry Day, Year) 2010 32. Segistrar's Sig						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2:05 AM March 2010 Doris 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 10, WVA 232-82-8694 64 Jan. 1946 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location show at 1 ☐ Yes 2x No Director items 23a or 28a-f s ser must be notified MD Prince Georges Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 4524 Natahala Dr. 20735 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2X Married 21215-0036 1 ∏ Yes 21 No Specify: If Yes, Give Year or Dates Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools event, the Teacher 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce. Fennissee Trigg Bertha Houston ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond Porchea - Husband 4524 Natahala Dr. Clinton, MD. 20735 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 4-1-2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD. 21. Signature of Funeral Service Licenses Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumocystis **Physician** preumonia disease or condition resulting in death) /Medical **Examiner** Sarcoidosi Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, physician Physician/Medical the 98 IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Month Day Year in the past 12 months? page 2 should be detached for 4 Pregnant at time of death
9 Unknown 5 Other (specify) 2 No the 9 Unknown The law requires that the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 XNo 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 2 No 1 Tyes certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ၉ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: or Attending 5 Pending investigation 1 X Natural 1 Yes 2 No after death. 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Division of Vital Records, 24 hours a within 2 To the I

> TUAN TRAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Bener S. face ORIGINAL

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 Year Physician/ March 27, 12:45 a.M Paterson Nancy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda 6203 Bannockburn Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** April 25 April 25 Days Hours Min. New York 1 □ M 2🗓 F 1953 56 104-44-8634 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Funeral Director notified a Bethesda 1 ☐ Yes 2X No MD Montgomery 28a-f 10g. Citizen of What Country?
United States 10f. Zip Code 10e. Street and Number 9 th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i 20817 6203 Bannockburn Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus once. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Reserve Bank Lawyer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Nancy Atwater Donald George Paterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 113 S. Herman Ave. Auburn, New York 13021 Sarah P. Reutlinger (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial A Cremation 3 ☐ Removal from State Marchate29. Belatsville, MD. 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRapp Funeral & Cremation Service era San ce Licensee 21. Sign We un 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Ovarian Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last ding physician Physician/Medical Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be del þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s 2 No this certificate 1 Tes 25. Was case referred to medica examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After injury work Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Directors 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Susan J. Miller, M.D.

Back

D35579

8218 Wisconsin Ave. Suite 305, Bethesda, MD 20814

March 29, 2010

m

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 22,2010 David Wallace Patton 3:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore #306 12320 Rosslare Ridge Rd. Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) ine 18,1930 Months Days Hours Pennsylvania 192-22-7871 Director 79 June Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 12320 Rosslare Ridge Rd. #306 21093 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+)

5+ YY'S Elementary/Seconday (0-12) 5+ Business Owner Electronics and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Patton Ruth Murray Davison George Coles permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maureen E. Patton - Wife 12320 Rosslare Ridge Rd. #306 Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Welliou of Disposition.

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fundal & rvice face cemetery, crematory or other place) Dulaney Valley March 26,2010 Timonium, MD 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on ea. h line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Orset and Death Immediate Cause (Final Physician, Schemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 25 years Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed years for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the salould be detached g 🗍 Unknown q 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 nesidence 6 Other (Specify) Hospital: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

101

State

29a. Certifier

(Check only one)

DHMH 17 Rev 7/2009

Lod

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Palardy Marie Gertrude 2010 1:00 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🛛 F Months Hours May 09, Year) 87 Washington DC Director 577-28-7305 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lutherville Baltimore 1 Yes 2X No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 1606 Greenspring Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 🛚 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Sis Mabel Bernard Holden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Greenspring Dr. Lutherville, Md. 21093 Mr. Kevin Palardy/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Mem. 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 3-31-10 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service License 22. Name and Ruck of Swison Funeral Home, Inc. <u> 1050 York Rd. Towson, Md. 21204</u> 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MODIC OBSTACED disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ☐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2000 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 27. Manner of Death Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signatture a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

P.O. Box 68760

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ARCH JOIO **Physician** 6:30 P Myrtle Ruth Ouinn /Medical 4b. City Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner HAR FORD AMU If Under 24 Hrs. RIVERS. 8. Date of Birth (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 6. Sex . Age (In yrs. last birthday) Security Number **Funeral** Vear) Days Months Hours 1 □ M 2 🛛 F Director 88 214-24-8551 July 6, 1921 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinist must be notified at once. 10a. State 1 ☐ Yes 2 🎇 No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1951 Melvin Drive 21040 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ∐Yes 2 TwNo Specify. þ Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Clittis (unk) Sparks Roy David Moxley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1943 Melvin Drive, Edgewood, Maryland, 21040 David Louis Quinn / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 3/30/2010 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician cardio-Avimnery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chartin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burlal-tran Chronic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 I Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 1 Yes Be ( 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Baltimofe, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

s after dec.
al Director: Aft filled in by within 24 hours a completely To the

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6/5 VID MP

and manner stated

31. Date filed (Month, Day,

MAR 30 2010

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

acthoril Ad hel Air, MM. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 16a per FH G902 4/1/10 dk
State of Maryland / Department of Health and Mental Hygiene - State Registrar #19a, perFH, G902, 4/21/2010, WS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 PECH Medical 4a, Facility-Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTZMORE COUNT TO WSON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, ) 7. Age (In yrs. last birthday) **Funeral** Months Min. Hours 1 □ M 2 🗶 F 86 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Maryland Director BALTIMORE 1 ŻYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Department of Health and Mental Hygiene. Important, frems 23a or Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be a one. Funeral U.5.A death y 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print)
Sherri Harper
ARA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MO. 2123 2036 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Butus ממבי AR BUTUS 4 Donation 5 Other (Specify) MD permit. 21. Signatur of Coneral Service Licensee 22. Name and Address of Facility ST. -BACTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COLONON disease or condition Medical resulting in death) Due to (or as a cons ence of): Examiner Seque itially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last signed by the attending physician a be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 \(\D\) has within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 200 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MOVON 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bluck louson Me lew senteur 31. Date filed (Month, Day, Year) 32. Pgistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CURTISS ROBINSON 3/27/2010 11:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 → M 2 □ F Months Days Hours Min. Director 444-24-3340 7/22/1929 Redbird,OK Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the Medical Eraninar must by modified at Director 1X Yes 2 ☐ No Capital Heights Maryland Prince George's the 10e. Street and Number 10g. Citizen of What Country? death with Funeral 1208 Benning Road 20743 United States permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or lany injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No ģ Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector Navy Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Auelria Davis Fred Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Robinson / Wife 1208 Benning Rd. Capt. Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 4/3/2010 Arlington National Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. Charles 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listorily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TATAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events due to (or as a consequence of): Examine attending physician and for use as the burial-transi P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year signed by the a d be detached fo 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2X No 3 Probably 4 Unknown s been si should t 1 ☐ Yes Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform After this certificate funeral director, page of Vital 2 No 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To spital or Attending Plours after death.
neral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number

State

State 31. Date filed (Month, Day, Year)
Registrar

32. Jegistrar's Signature

K. CKWI

ch 29, 2010

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Griffin Days 3001 HOSpital DR Cheverly, MD 2078.

D63688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death \$:45 PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William David Roland, Jr. Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner slen BUTTIE Anne Arundel Baltimore Washington Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Hours Min. (Month, Day, Mary Land 215-30-1112 76 Director 1933 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director event, the Medical Examiner must be notified Maryland Glen Burnie 1 ☐ Yes 2 X No Anne Arundel 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? 23a Funeral 21061 USA 103 Longwood Avenue items should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc "natural", or Completed by 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Auto Body Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William David Roland, Sr. Lena Lucille Howdrsheldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 103 Longwood Avenue Glen Burnie, Maryland 21061 Joyce M. Roland, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State 3/29/10 Baltimore, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Marylan, Inc. Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ed by the a detached f Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Ö signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. <u>۾</u> Division of Vital Records, 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \to \) Nursing Home 5 \( \to \) Residence 6 \( \to \) Other (Specify) 2024 No Hospital: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes Accident 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certific

31. Date filed (Month-Day.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tospit

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:46a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay. **Funeral** 1**⊠** M 2□ F Months Days Hours Min Year Yrs. 88 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar mast be notified at MD Carrol1 Westminster 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Timber Ridge Drive 21157 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1√PYes 2 No 1942− IfYes, Give Year or Dates: 1944 Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or þ 1 □Yes 2 □▼No Specify Specify: white 3 N Widowed 4 □ Divorced Completed the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) transportation truck driver is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental James Gilbert Randall Kathleen Cordell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Stephanie Heck (executor) 6945 Woodbine Rd., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet. 3-29-10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage Spaight of P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Examir The law requires that the death certificate be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy performed? /es 2.2100 certificate ospital or Attending Physician: The hours after death.
Ineral Director: After this certificate by filled in by the funeral director, pag 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital o 24 hours af e Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Consider the control of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only the 29b. Signature and title of certifies 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRENDAN HENDERSON M.D. 200 MEMORIAL AVE, WESTMINISTER MD 21784

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ 25 Robert C. Ragan 11:25 P M March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Hours Min. Dec. 30, 1915 Missouri Director 577-24-8328 94 Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ¥ Yes 2 ☐ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7216 Chestnut Street 20815 United States 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian .0. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates d other than "natura went, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Accounting Firm item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Heinlein Ragan Mary Clark permit, Page 1 and 2 should Department of Health and M Important: If item 27 is man any Injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Ragan/Son 1237 N. Avon Street, Burbank, California 91505 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) April 3, 2010 | Rockville, Maryland Signay e of Funeral Service hou a R<sup>3</sup> Name and Address of Facility Tuneral Home/Bethesda—Chevy Chase, Inc. toron M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗌 No death Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

filed (Month, Day, Year)

12V

completed cause of death (Item 23a) (Type, Print)

		State of Maryland					2.0	10 00680
		Registrar  1. Decedent's Name (First, Middle, Last)	- 06	ertificate of L	Jean	2. Date of De	Reg. No. U	3. Time of Death
Physicia	n					Month	28, 201	Year
/Medica Examine	- 2	James         Hamilton         Rock           4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	March	4c. County	
Zamme		214 Gateswood Road		Timon	ium		Balti	more
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthda		If Under 24 Hrs. Hours Min.	8. Date of Birt	th	Birthplace (State or Foreign Country)
Director		215–12–8666	Yrs.	IVIOTITI'S Days	Tiours Will.		2, 1922	Maryland
pus *	-	Usual Residence of Decedent         10a. State         10b. County         10c. City	, Town or	Location				10d. Inside City Limits
//aryla	ō							1 □Yes 2 <b>X</b> No
the 1 28a- notif	Director	Maryland Baltimore 10e. Street and Number	Cimon	10f. Zip Code		T	10g. Citizen of W	What Country?
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deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. 13	B. Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No		e - American Indian, k, White, etc.
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ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10- D-		-N			wnite
n 72 "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gir	cedent's Usual Occupa ve kind of work done of DO NOT use retired	ation during most of wor. ()	king	160. Kind of Bu	siness/Industry
withi iene. than	Ë	Elementary/Secondary (0-12) College (1-4or 5+)		elf Employ			Sign	Company
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Inial yialla ZIZISIOUOOO Ind 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip Code)
로 함께 등 등 등		Patricia Rock/Wife		Gateswood	l Road T	imonium		.093
Pages 1 and of Hee		20a. Method of Disposition 20b. Pl 1	ace of Dis emetery, c	position (Name of rematory or other plac	ce)	Date	20c. Location -	City or Town, State
permit. Pages Department of Important: If It any Injury or o	1	4 Donation 5 Other (Specify) Gard	dens	of Faith C	Cem. 3/3	1/2010	Baltimo	ore MD
Dall permit Depar Impor any In		21. Signature of Funeral Service Licensee		22. Name and Address Miller-I	ss of Facility Dippel Fu	neral H	ome, Inc	
4 4 5 6 6	+	22a Part System the dispute of complications that caused the death	Do not o		air Road			21206 Approximate
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Physician /Medical		disease or condition resulting in death)		mora	dia	mil	ru	- Kenns.
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vical mecologs, r.C. box o siden: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	in the past 12 months?	death :	3 ☐Ectopic pregnancy	/			te of delivery enth Day Year
the d	Ì	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Jan	o line (speedily)				
that hed by deta		Part II. Other significant conditions contributing to death but not resu	- //		en in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?
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aw requ	Completed	typerlen-				24a. Was		Wore autopsy findings available
The ta	Eo					auto perf	ormed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
rtiffica	a	25. Was case referred to medical			26. Place of Dea			
hysic his ce	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient 2	ER/Outpat	ient 3□ DOA Oth	er: 4 Nursing H	lome 5 Res	idence 6 □Oth	ner (Specify)
ng Phy (fter thii		27. Manuel of Death 1 ✓ Natural 5 ☐ Pending (Month, Day Year)	28b. Time Injur	y Wor	k?	28d. Describe	how injury occur	red
tendl eath. for: A	cati	2 Accident Investigation			Yes 2 □ No			
or At or At or At or At or At or At	Certification:	4 Homicide determined 28e. Place of injury - At ho building, etc. (Specify	me, farm,	street, factory, office		City or To	(Street and Numb wn, State)	per or Rural Route Number,
pital ours a beral l		29a. Certifier 1 Certifying Physician: To the best of my kno	wledge, de	eath occurred at the ti	me, date and place	e, and due to the	e cause(s) and m	anner as stated.
e Hos 24 hr e Fur letely	Medical	(Check only 2 Medical Examiner: On the basis of examina one) and manner stated.	tion and/or	r investigation, in my o	opinion, death occi	urred at the time	, date and place,	and due to the cause(s)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	- 1	29b. Signature and title of certifier	_	29c. Licens			-	ed (Month, Day, Year)
		> MIMMic.	19.9	100	18350	7	KALE	14 29 2010
111		30. Name and address of person who completed cause of death (item	23а) (Тур	e, Print) 890	3 H	ARFO	カカク	74 D
121		CPA WATTER	tura	BAL	4-1	Atra	1 AMO	21234
Stat Registra	e	31. Date filed (Month, Day, Year)						
		MAR 3 0 2010 Denoute S.	your					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

2434

31. Date filed (Month, Day, Year)

BALTIMORE

AVENUE

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland /	•	artment o			nd Me		giene Reg. No.?	10	19682
	Physici		1. Decedent's Name (First, Middle	A =	LOAR	(					2. Date of De. Month MARCH	ath Dav	Year 2010	3. Time of Death  00.5/AM
i i	/Medio		4a. Facility Name (If not institution,	give street and number			4b. City, To					4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 231–32–3330		ge (In yrs. last 80	birthday) Yrs.	If Under 1 Months C	/ear )ays	If Under 2 Hours	Min.	8. Date of Bird (Month, Da	y, Year)	9. Birthi Coul NC	place (State or Foreign ntry)
	Maryland -f ehow	Į to	Usuel Residence of Decedent  10a. State 10b. County  Maryland Harfo	rd	10c. City, To									10d. Inside City Limits
	th with the 23s or 28s	Funeral Director	10e. Street and Number 146 Allendale	Ave.			10f. Zip Co	ode 100	1		J	10g. Citizen o	of Whal Cou	ntry?
9036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 ie marked other than "naturel", or iteme 23e or 28e-f ehow application of the traumatic event. Ite Medical Examination mail be coallined at anothe.	d by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces ed 1 Yes 2 1 If Yes, Give Year or Dates:	.? ]No	'	Was Deceder f Yes, specify	Cuban,	panic Orig , Mexican, Specity:	in? (Spec , Puerto R	city Yes or No lican, etc.)	8	Race - Ameri Black, White, ciWhit	etc.
21215-0036	ad within 72 h gjene. er than "natu . Ine Medical	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)		5+)	(Give	dent's Usual ( kind of work ( DO NOT use )	done du		of workin	g	Manu		
Maryland	ould be file Mental Hy larked oth	To Be (	17. Father's Name (First, Middle, I Andrew Alexan	der Brook				С	arri	e E	dith N	Maiden Sum Willia	ams	
	s 1 end 2 sh if Health and item 27 ie m other traum		James Roark / 20a. Method of Disposition	Son	20b. Place	146		dal	e Av	7e,		er, City or Tow en I 20c. Location	MD 21	001
Baltimore,	permit. Page Department o Important: if eny injury or once.		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St.  21. Signature of Fineral States	pecify)	8	e Pr	esb.	Cem	of Facility	,		Aberd		
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	line.	Do not ent	er the mode of	of dying,	such as o			Home, een, I	мĎ 21	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  Sequentially list conditions,	Due to (or a	STATIC s a consequen	ce of):	S CAI	ICE N						1 YEAR
8760,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Ilcai Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequen			-						A New York
P.O. Box 68	the death certifica y the attending ph ched for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2   Fetal de at time of death	ath 3	Ectopic preg Other (spec						Date of deliv Month	ery Day Year
	quires thet in signed bi uld be deta	ed by Pr	Part II. Other significant condition	TISTALE , PL	LLTED WA	417	471629	~//c	1,6					the cause of death?
Division of Vital Records,	Attending Physicien: The law requires thet the rideath. sctor: After this certificate has been signed by the the funeral director, page 2 should be detached.	Completed	STROKE AN MELLITUR, A			, (	14 13	ETE	5	_	24a. Was auto perfo 1 Yes	psy ormed?		opsy findings available ompletion of cause of 2 No
Vita	sicien: s certific lirector,	To Be	25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No	Hospital:	tient 2□ER	Outpation	2 DOA				Check only	one) dence 6 🗆	Other (Care	4.1
ion of	anding Physicien: The lavath. The sertificate has or: After this certificate has he funeral director, page 2	ation: T	27. Manner of Death  11 Natural 5 Pendin 2 Accident investig	28a. Date of In (Month, D	jury 28	b. Time of Injury		. Injury a Work?	at	2		how injury oc		19)
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of I	njury - At home etc. <i>(Specify)</i>	, farm, str	eet, factory, o	office		2		Street and Nu wn, State)	mber or Rui	al Route Number,
	To the Hoepital or within 24 hours after To the Funeral Dircompletely filled in its	edicai	29a. Certifier TC Certifyin (Check only 2 Medical I	g Physicien: To the bes Examiner: On the basis and manners	of examination	dge, deatl and/or in	h occurred at vestigation, in	the time my opi	, date and nion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To th within To th comp	×	29b. Signature and title of certifier		,				number	D		29d. Date sig	,	
7			30. Name and address of person	who completed cause of	doub /ltom 22	3a) (Tyne	Deint)							2010
			ALW SWEATT	W. HARFOR	es Me	MURI	AL HO	5511	TAL,	HAUR	LE DUCK	RACE	2107	78 ,
	Sta Regista		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	9	arker							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Sauter Patricia Α. 28 2010 1:00 pM March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5220 Old Frederick Road Baltimore Baltimore Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours Min. (Month, Pay, Year) 12 11. 1943 Country) Mary Land Director 218-42-0095 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5220 Old Frederick Road 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Joseph Stilling Josephine Marie Spadaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bayfront Road Sparrows Point, Maryland 21219 Lisa P. DeRoose, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/01/10 Loudon Park Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Ceorge MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 MacNabb E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final ChroNic UIMONARU .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute signed by the attending physician and doe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an certificate has autopsy Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural injury work?
1 Yes 2 No 5 Pending Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar beech H Miller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3455

gistrar's Signatur

29c. License number

006982

WILKENS AVE SUITE 250 Ra

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Charlestown Care Center Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days Hours Min Director 218-26-6976 MAR Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Baltimore Catonsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane, BR 635 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 Divorced 4 Divorced Specify: White Completed Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Media Teacher's Aid Baltimore Co. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anthony Dalfonzo Jenny Dalfonzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Schwartz, 719 Maiden Choice Lane, BR635 Catonsville, MD 21228 Husband permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/30/2010 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation Society of MD, Inc. George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final <sup>2</sup>hysiciali/ disease or condition Small **Viedical** resulting in death) Due to (or as a consequence of) ≤xaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 IN 25. Was case referred to medical examiner? Be the funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and title of certifier 29c. License number 3/29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228

Registrar
DHMH 17 Rev 7/2009

Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 25<sup>Day</sup> 2010 ear March 4:40 pM Geraldine Theresa Schmitt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 8265 Camion Court Pasadena Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Director 84 Maryland 213-20-8855 Usual Residence of Decedent show ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔯 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8265 Camion Court 21122 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph L. McNulty Christine C. Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shument of Health a tant: If item 27 is Edward H. Schmitt/ Husband 8265 Camion Court, Pasadena, Maryland, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 26, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road Baltimore. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year the : Unknown 9 Unknow signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy performed? Yes 2 Nc prior to condeath? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No မ 1 Yes After this c 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A pumpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signa 29c. License number 29d Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

10-02371

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Seese	1- For State Registrar	state of Marylan	d / Departm <i>Certific</i>			Menta		Reg. No.	2010	09688
Physician/ Medical Examiner	1. Decedent's Name (First, Mid		-				2. Date of De Month March 25	ath Day	Year	3. Time of Death 0622 hrs
	4a. Facility Name (if not institute St. Agnes Hospital	ion, give street and numb	per)	4b	. City, Town, or Le Baltimore	ocation of I			ounty of Death	/A
Funeral Director	5. Social Security Number 212–86–6829	6. Sex 7.	Age (In yrs. last birl	hday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	28, 19	YYYYY) 9. Birt	hplace (State or Maryland Intry)
w any	Usual Residence of Decedent 10a, State 10b, Count		10c. City, Town							10d. Inside City Limits 1 X Yes 2 No
the Maryland n or 28a-f show tified at once. Director	Maryland  10e. Street and Number	N/A		timor	10f. Zip Code			10g. Citizen	of What Cour	
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director		12. Was Decede	ent Ever in U.S. es?			anic Origin	? ( Specify Yes or Nuerto Rican, etc.)	0- 14.	USA Race - Americ White, etc.	can Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once TO Be Completed by Funeral Director	3 Widowed 4 XD	ivorced if Yes, Give Year or Dates:		Decedent's	es 2 X No	n (Give kin			ecify: Whi	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Byggene.  In the m 27 is marked other than "natural", or other traumatic event, the Medical Examiner.  To Be Completed by I	Elementary/Secondary (0-12	College (1-4	or 5+)		t of working life. I house Wo		e retired)	Foc	d Serv	ice
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than its event, the Medical FO BE COMPIE	Richard E. See	se				Mari	Name (First, Middle,	3	·	
, MD 21 and 2 should saith and Me em 27 is ma raumatic es	19a. Informant's Name/Relation  Donna Woods, S  20a. Method of Disposition		6	713 1		an Hil	er or Rural Route Nu L1 Rd. Bal Date	ltimor		21222
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other ti injury or other traumatite event, the Med	1 Burial 2 X Crematic 4 Donation 5 Other 21. Signature of Funeral Service	Specify:	State cremat	ory or othe Crem	atory, I	Inc.	3/26/2010	Balt	timore,	Maryland
Physician  Physician	alice Il	Ser A	lice Iser	299	Frederi	lck Ro	oad Baltir	nore,	Maryla	ryland, Inc. nd 21228 Approximate Interval
Examiner	failure. List only one caus  Immediate Cause (Final diseas or condition resulting in death)	e on each line. Methado e a. Due to (or as a co		icati	on					Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b. Due to (or as a co	nsequence of):							
be executed ician and urial - transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):							
760, sate be execut physician and he burial - tra	IF FEMALE:	230. If yes, out	,27,28a-f	, per	ME g902	4/19	/10 TT	23d. D	ate of delivery	
). Box 68760, the death certificate by the attending physiched for use as the burnerly Physician/Med	23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U	I Elve piliti	at time of death		death 3	_Ectopic p	regnancy	Mo	onth D	ay Year
P.O. B res that the d signed by the be detached i	•	itions contributing to de	eath but not resulting	g in the und	lerlying cause giv	ven in Part l			_	he cause of death?
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by ledical Certification: To Be Completed by Physician/Me							24a. Was auto perfe 1 🗸 Yes	psy ormed?		opsy findings available ompletion of cause of
f Vital Rec Physician: The ler this certificate la director, page To Be Com	25. Was case referred to medic examiner?  1 ✓ Yes 2 No		atient 2 🗸 ER/O	utpatient	- 10	ther —	neck only one) lursing Home 5	Residence	6 Other	
ion of tending Pheratur. After the funeral ation: T		28a. Date of I (Month, Da ding estigation Fd 3/2	injury 19,Year) 28b. 5/10 unk	Γime of Inju		at Work?				
Division of A Division of W Division of W Division of Autending Ph Within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral edical Certification: T	3 Suicide 6 X Cord	ermined (Specify)	f Injury - At home, fa house				Baltimo	State) 4 I ore, M	DWilker	
To the Hospital within 24 hours To the Funeral completely filler	(Check only	Physician: To the best of aminer: On the basis of e and manner state	xamination and/or in			death occur		and place,		cause(s)
	Lunch 9 Ven	thall, mo			O.C.M				25, 2010	in, Day, real)
1 peres	30. Name articladdress of person Pamela E. Southall,		of death (Item 23a) edical Examine	r 111	Penn Street.	Baltimor	e, MD 21201			
State		,	trar's Signature							

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For	Please	State of N		d / Depa	artmer	nt of H	lealth	and N	1ental Hy	giene	•	le.		
		Registrar  1. Decedent's Name				Cei	rtifica	te or i	Death		2. Date of De			LU	3. Time	of Death
Physic /Medi				eth Sine			T				March	26	201			2 p M
Exami	ner	4a. Facility Name (#Longview			r)		4b. City	Town, or Tanch	Location estel	of Death		40	. County of Carr	Oll Oll		
Funeral Director		5. Social Security Nu 213-12-94	72	Sex 7.4	89	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Fellonth, Da	th y, 1/000)	1	Birth	place (State intry) y Land	e or Foreign
land ow		Usual Residence of I 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation							- T	10d. Inside	City Limits
ie Mary 8a-f sh	ctor	Maryland	Carrol:	L	]	Finksb										es 211 No
with the	I Dire	10e. Street and Num 2230 R:	<sub>idgemon</sub>	t Dr.			10f. Zi	p Code 2104	-8			10g. Ci	tizen of Wh U.S			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evatral and must be neithfied at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Deceder Armed Force 1 Tyes 24 If Yes, Give Year or Dates	s? ] No	- 1	Was Dece If Yes, spe 1  Yes		lispanic Or an, Mexica Specify		ecify Yes or No Rican, etc.)	)-		White,		
72 hou natura	eted		15. Decedent's			16a. Dece	dent's Usi	ual Occup	ation	st of work	ina	16b. k	(ind of Busi			
within iene. than "	Completed	Elementary/Secon		College (1-4o	r 5+)		DO NOT I		during mos d)		9	H	lomema	ker		
uld be filed fental Hyg rked other	To Be Co	17. Father's Name (A		*							e (First, Middle Virgin				_	
and 2 shouealth and N 27 is mainer trauman		19a. Informant's Nat		(Type. Print) a daught		2230	Rida	gemon	it Dr.	. Fin	al Route Numb iksburg	, MI	. 210	48		
Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disp 1	Cremation 3	☐ Removal from Sta	20b. F		Mem.	. Gar	dens	Marc	ch 30,2	010	Marr	riot		le, MD
permit. Depart Import any Inj		21. Signature of Fur	neral Service Lid	ensee							nardt F					
Physician /Medical Examiner		23a. Part 1. Enter th shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List on Final	a. Due to (or	line.						t Cur				Approxin Interval E Onset ar	nate Between nd Death
D ##	iner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or i	iditions, mediate lying	b. Due to (or	as a conseq	juence of):			nee		,,,,		-		ر سا	- Pu
executed in and ial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L	_	c. Due to (or	as a conseq	Juence of):									154	hs
be licia				d. ad	me	ed l	age								89	gr .
Attending Physician: The law requires that the death certificate by closh.  crosh.  cror: After this certificate has been signed by the attending physicion by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 t 1 ☐ Yes 2 ₽ 9 ☐ Unknown	months?	23c. If yes, outcor 1 ☐ Live birt 4 ☐ Pregnar g ☐ Unknow	n 2□Feta tattime of o	al death 3	□ Ectopic		у				23d. Date Mon		very Day	Year
w requires that so been signed by should be deta	Part II. Other significant conditions continuously to death out not resulting in the didentitying cause given in Part I.															
The law rec ate has bee page 2 shou	24a. Was an autopsy performed? 1   Yes 2   No   No   No   No   No   No   No										ngs available of cause of					
slclan: certific rector,	Be	25. Was case referr examiner?		Hospital:				Ott			th (Check only					
ng Phys fter this	on: To	1 Yes 2 2 27. Manner of Death 1 Natural	`	1 □ Inp		28b. Time of Injury		28c. Inju Wo	4 12 1	Nursing H	ome 5 ☐ Res 28d. Describe				cify)	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide	investiga 6  Could no determin	t be 28e. Place of	Injury - At h etc. <i>(Sp</i> ec <i>i</i>	ome, farm, st	M reet, facto		Yes 2	]No	28f. Location City or To	(Street a	and Numbe te)	er or Ru	ural Route N	Number,
To the Hospital or within 24 hours afte To the Funeral Dirucompletely filled in I	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)															
To the within To the comple	Mec	29b. Signature and	title of certifier			·	2	9c. Licen	se number			29d. D	ate signed	(Monti	h, Day, Yea	r)
		ph	m W. D.	midlite	n 'n	ND		DZ	54	43		31	29/2	20	10	
4		30. Name and address	ess of person w	no completed cause of	of death (Ite)	m 23a) (Type 688	Print)	le 1	Ra.	W.	es tim in	5%	or. W	10	211	57
Si Regis	ate trar	31. Date filed (Mont	AR 3 0 2	010 Reg	strar's Signa	1. A	ade		,		es ton n		,			

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dey 23 **Physician** 4:20 17 2010 03 Simith-Taylor /Medical 4e Fecility Neme (If not institution, give street end number)
RIGGEWAY MAROR N. H 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Ridgeway Baltimore Md. 21228 If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex **Funeral** Deys Hours 1 M 2 TE Months -05 MD 62 Director 212-44-5995 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland one) of Health and Mental Hygiane. In the Marylane in the filem 27 ie marked other than "natural", or items 23s or 28e-f ahow mix! if item 27 ie marked other than "natural", or higher traumatic event, me Medical Exemples mant be notified at my or other traumatic event, me Medical Exemples mant be notified at 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 ☐ Yes 2 XNo by Funeral Director Salisburg Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21801 U.S.A. 814 Riverside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married X Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Post Office 12thgrade 2yrs Postmaster 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Eva Molly Horace Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) 2808 Gatehouse Drive Apt B, Baltimore, Shawn Smith-Son
20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Department Important: If any injury or price. 4/7/10 Baltimore, Md On-Site 21. Sign are Funeral Service Licensee Managed Add to Freits t 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part I. Enter the disease, or complications that couled the shock, or heart failure. List only one cause on each line Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical 1 year Snaucell Caicinomo. o. Metaclare Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown At breach concining 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Huges him dues 1 Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Notring Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation Injury 1 Netural after death.

Director: After the function of the post of the function of the 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 24 hours Fun rai 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier within 24 hor To the Fun-completely fi (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19667 03-23 2010 Hereal VILLOUTION \* 508 Class Boing 719 5106/ 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Retalice 12 acros 7310 31. Dete filed (Month, Day, Year) 32. Registrer's Signetur

**DHMH 16 Rev 6/95** 

State

Registrar

MAR 30 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		-	For State Of Ma	iryiand / Depa <i>Cer</i>	artment of H tificate of D			gierie Reg. No. 🔿 🔘 📗 (1	00000
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month	7 11 11	3. Time of Death
	Physicia Medic	al .	John Richard Sheeler,	Jr.			March	25 2010	5:15 A <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Towson	Location of Death		4c. County of Deat Baltimor	
	Funeral	•	GBMC  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	9. Bir	thplace (State or Foreign
	Director		212-26-6352 1X M 2 G F	81 Yrs.	Months Days	Hours Min.	Jan. I	6 1929 MI	(untry)
	land show d at	è	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation	-	<del></del>		10d. Inside City Limits
	Maryla 18a-f tified	Funeral Director	MD Baltimore	Timonium	l				1 ☐ Yes 2 😾 No
	a or 2 be no	<u>E</u>	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	th with ms 23	ner	14D Breezy Tree Ct.		2109		osifu Voc or No	USA	ation Indian
Maryland 21215-0036	is filed within 72 hours after death with the Maryland tall Hyglene. And Hyglene detection of other than "natural", or items 23a or 28a-f sho edent, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ☒ I If Yes, Give Year or Dates.	verin U.S. 13. V	Was Decedent of His f Yes, specify Cubal I ☐ Yes 2【 No		Rican, etc.)	14. Race - Ame Black, Whit Specify: <b>wh</b>	
15-0	72 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of Business	Industry
212	iled within 72 Il Hygiene. other than ' vent, the Me		Elementary/Seconday (0-12) College (1-4 or 5-	+)	lial Agen	t/Mainter	ance	AAI	
pu	filed v al Hyg d othe	Be c	17. Father's Name (First, Middle, Last)	- · · · · · · · · · · · · · · · · · · ·		18. Mother's Nam	e (First, Middle, Jeona Pe	,	
ryla	2 should be file th and Mental I 7 is marked o traumatic eve	욘	John Richard Sheeler						in Codal
Ma	d 2 sho alth and 127 is r er traun		19a. Informant's Name/Relationship (Type, Print) Cindy L. Riddick/daughter	3015	Lavende	r Ave., I	arkvill	e, MD 21234	<b>4</b>
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  X Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Bonjation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Dulaney	natory or other plac	<sub>e)</sub> 3/29 morial Ga		20c. Location - City or Timonium,	'
Balt	permit. Departr Import. any inji		Egypt Willary My	L <sub>e</sub>	Name and Address Fun 10 W. Pad	ss of Facility eral Home onia Rd.,	of Dul	aney Valle um, MD 210	y, Inc. 93
			23a. Part . Enter the disease, or complications t at cau ed sho k, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
8	nysician/ Medical	10	Immediate Cause Final disease or condition a. Pue to (or as a	consequence of):	INFA	retion			Oriset and Beauty
	Examiner		But to for as a	10000 W 02000	VAL FA	HWA			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence off:					
ķ.	cate be executed physician and the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events c	Hrom C	16NAL	FAILU	25		
_	be exesician burial	calE	d d	, ,					
3760	ficate g physas the		- G				-		
Box 68	the Hospital or Attending Physician: The law requires that the death certificate be executed find 4 hours after death.  The A hours after death.  The Advines after death.  The Experimental Director: After this certificate has been signed by the attending physician and pletted filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 🗌 Fetal death 3 🛚	☐ Ectopic pregnand ☐ Other (specify)			23d. Date of de Month	elivery Day Year
s, P.O.	res that the des signed by the s d be detached t	Completed by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause giv	ven in Part I.		obacco use contribute t	o the cause of death?  Probably 4 Unknown
Records,	v require s been si should l	olete					24a. Was		utopsy findings available completion of cause of
3ec	The law cate has page 2:	mo						rmed? death?	es 2 No
tal	nysician: The nis certificate I director, pag	Be	25. Was case referred to medical examiner?			ace of Death (Chec			
f Vii	Physic this or al dire	은	1 Yes 2 No Hospital: 1 Inpatie  27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatier v 28b. Time o		4 ☐ Nursing H		dence 6 Other (Spe	cify)
o u	oding l th. : After e funer	cate	1 Natural 5 ☐ Pending (Month, Da) 2 ☐ Accident Investigation	(Year) injury	work	? Yes 2 🗆 No	200. 200011501	on many coodings	
Division of Vital	Il or Attendi safter death. Director: A d in by the fu	Certificate:	O Could not be	iry - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or Re vn, State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of enly one) 3 Certifying Nurse Practioner: To the	xamination and/or inves	stigation, in my opinic	on, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 $\square$ Certifying Nurse Practioner: To the 29b. Signature and title of certifier	best of my knowledge,	29c. License	e number	so, and duo to the	29d. Date signed (Mon	
	)		1 G V m		050	0232		3/25/1	0
	2		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, I	Print) ke Rd. Si	ite 312.	Sparks	, MD	
	() Sta	te	31. Date filed (Month, Day, Year) 32. Registra						
	Registr		MAR 30 2010 Ceneral &	ay's Signature					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Irene Sawtell March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Burnie <u> Anne Arundel</u> Glen. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛱 F Months Days Hours Min. July 13, Director 507-26-8686 83 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10c. City, Town or Location Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1814 Quebec Street 21144 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Completed and Mental Hygiene. is marked other than "natural raumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Church Elementary/Seconday (0-12) College (1-4 or 5+) Seventh Day Adventist Administrative Secretary Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kobiela Mable Frank Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Severn, MD 21144 Mr. James F. Sawtell / 1814 Quebec St. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔲 Burial 2 🗶 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3/27/2010 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral and Cremation MON2 | Services, PA. 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. Immediate Cause (Final EREBROVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a nonsectionne of if any heading to trained at cause. Enter Underlying Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident 3 Suicide Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALLACE: IM 31. Date filed (Month, Day, Year) 32. Regis State Registrar

Ewallace MID

29b. Signature and title of certifier

KICBRIDERD, BALTIMORE, WID 21236 9005

03/136

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3. Time of Death

6:38

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

1 Yes 2X No

Country) Nebraska

DHMH 17 Rev 7/2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<sup>Pay</sup> 20°10 Physician/ March 9:30AM S1echta Charles Louis Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicim of Linthicum Heart Homes Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Days Hours Aug. 17, 1920 Months MD 89 Director 212-18-9753 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Linthicum MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 U.S.A. 804 South Camp Meade Road Room 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death \ 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No White Specify 3 ☐ Widowed 4 ☐ Divorced f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric Electrician 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Barbara Klement Frank Slechta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9715 Uxbridge Road Parkville, MD 21234 Mrs Janice Chason/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition March 30. Department of H Important: If ite any Injury or ot 1 D Burial 2 X Cremation 3 D Removal from State Glen Burnie, MD Atlantic Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final our Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year 1 Yes 2 No cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 Do 7 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes certificate Yes 26. Place of Death (Check only one) director, Be 25. Was case referred to medical examiner? 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 to Other (Specify) မ 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: After injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation Could not be after death Director: A I in by the f Accident 6 🗌 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Discompleted filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Mpnth, Day, Year) 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) 30. Name address of p Madvar Gorbalymo 32. Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	tate of Marylan		rtment of F tificate of D		Mental Hy	giene Reg. No.	010	09692
	Physicia	2/	Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
	Medic	al .	MICHAEL JOHN SV 4a. Facility Name (if not institution, give stree		•	4h City Town or	Location of Death	March 2	26, 201		11:30 ₽
	Examin		300 Oak Street	and Hambony		Edgewo	_		1	ford	
	Funeral Director		5. Social Security Number 6. Sex	2 F 7. Age (In yrs. Id	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 4, 1925	9. Birth Cou	nplace (State or Foreign ntry) <b>Illinois</b>
			Usual Residence of Decedent	85	113.			Jan. 2	4, 1925	<u>,                                    </u>	IIIInois
	ryland I-f sho ied at	ctor	10a. State 10b. County		y, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🔀No
	he Ma or 28a e notif	Dire	Maryland   Harford  10e. Street and Number		dgewood	10f. Zip Code		-	10g. Citizen	of What Cou	
	s 23a uust be	Funeral Director	300 Oak Street			21040			USA		
٥	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by Fur	- Indirect States	Was Decedent Ever in U.9 Armed Forces? 1 X Yes 2 ☐ No If Yes, Give	If	/as Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	В	lace - Ameri Black, White,	, etc.
2-003p	ours aff tural", al Exa		3   Widowed 4   Divorced	Year or Dates.		Yes 2 X No			Spec	Whit	e
٠ د	an "na Medic	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give k	ent's Usual Occupa ind of work done o ONOT use retired)		king	16b. Kind of	f Business In	ndustry
7	l withir ygiene her tha t, the			College (1-4 or 5+)	Solo	lier			U.S.	Gover	nment
and	be filed antal H ked ot c ever	To Be	17. Father's Name (First, Middle, Last)  Michael John Swital	ski Sr.			18. Mother's Nan	ne (First, Middle, Elizabe			·i
ary	should be fill and Mental is marked of aumatic eve		19a. Informant's Name/Relationship (Type, F		19b. Mailin	g Address (Street a					
e, Mai	tind 2 s fealth a im 27 i		Helen R. Switalski			Oak Stre	et, Edge	wood, M			
saitimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.	- 1	20a. Method of Disposition  1 ☐ Burial 2 🂢 Cremation 3 ☐ Rem	oval from State	emetery, crem	sition (Name of atory or other plac		Date	20c. Locatio	•	
altin	mit. Papartme portan portan / injury	Ì	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licentee	1 #1		Service C Name and Addres		0/2010 McComas			Maryland
מ	permir Depar Impon any in		Dallara Ki	udh		317 Cokes	bury Roa	d, Abin	gdon, N		
			23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca Immediate Cause (Final	ions that caused the deat use on each line.	h. Do not ente	r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death:
	Physician/ Medical		disease or condition resulting in death)	Due to (or as consequence	uence of):						Onset and Death:
	Examiner	_	Sequentially list conditions, b								
	ed	Examiner	if any, leading to immediate  Cause (Disease or linjury	Due to (or as a consequ	uence of):						
	execut an and ial-trar	Exa	that initiated events c. = resulting in death) Last	Due to (or as a consequ	uence of):						
9	cate be executed physician and the burial-transit	edical	d							$\longrightarrow$	
βQ	certifica nding p			If yes, outcome of pregna					23d	Date of deliv	verv
X Q Q	death	Physician/M	in the past 12 months?	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		Ectopic pregnand Other (specify)	у			Month	Day Year
л Э	nat the ed by tt detach	F.	Part II. Other significant conditions contrib	uting to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use co	ontribute to	the cause of death?
JS,	uires then signer and be	ed by	COPD					1 😿	Yes 2 No	3 □ Pro	obably 4 🗆 Unknown
000	aw red las bee	Completed						24a. Was	psv	prior to co	opsy findings available ompletion of cause of
Ž Ž	trhe licate l'icate l'		25. Was case referred to medical						ormed? 2 No	death?	2 🗆 No
VIta	ysiciar is certii directo	To Be	examiner?  1 Yes 2 No	ital: 1  lnpatient 2	ER/Outpatien	Othe	ace of Death (Checer:	ome 5 KResi	dence 6∏0	)ther (Specif	fv)
0	ing Ph ifter thi uneral		27. Manner of Death  1   ✓ Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	y at ?	28d. Describe			//
Division of Vital Records,	Attend death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, stre		Yes 2 No	28f. Location (	Street and Nur	mher or Run	al Route Number,
<u>≥</u>	ital or / urs after al Dire	al Ce		building, etc. (Specif)				City or To	vn, State)		
i.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  2 Medical Examiner: 3 Certifying Nurse Pr.	On the basis of examinatio	n and/or invest	igation, in my opinic	on, death occurred a	at the time, date:	and place, and	due to the ca	ause(s) and manner stated.
1	Voithi To th		29b. Signature and title of certifier	anter MD		29c. License	number 57520		29d. Date sig	ned (Month, 23/2	Day, Year) 9/2010
			30. Name and address of person who comp		23a) (Type, P			elcamp,	MD 2	1017	7
	Stat	е	31. Date filed (M3th Day 2010 Le	32. Registrates Signa	barlo		/	1 /			
	Registra	17	MALLEY A O POLO LANGE	1 1/							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2010 Lucille B. 1:30 РМ Sevmour Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1 Stonebridge Court Montgomery Germantown Social Security Number 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Funeral 1 □ M 2 🛣 F Days Hours Min 048-22-8478 December 13. 80 1929 Director Connecticut Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 1 Stonebridge Court United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supply Company Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Biondi Mary Grace DeNicola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Karta / Daughter 1 Stonebridge Court, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 31. 1 X Burial 2 Cremation 3 Removal from State Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Waterbury, Connecticut Signature of Funeral Service Licenses R<sup>22 Name and Address of Facility</sup> Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 Years Physician/ Myelodysplasia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or imjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ဳ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 ☐ Yes 2 🗶 No 1 Yes 2 No s after death.

I Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a, Certifier ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D43083 March 23, 2010

12V

DHMH 17 Rev 7/2009

State Registrar 9707 Medical Center Drive, Ste. 300, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Month March Physician/ 25 Annie B. Scheckel 4:39 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ine 22, 1932 1 □ M 2**X** F Months Davs Hours Min. Virginia Director 229-36-1293 77 June Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Tes 2X No Maryland| Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14411 Traville Gardens Circle 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Brakson Pullen Sadie Lee of Health and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 Michael B. Cassidy/Son 3531 Old Grandad Lane, Chesapeake, Virginia 23323 Baftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Yontgomery
Crematorium, Inc. 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State March 30, ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2010 21. Signature of Funeral Service Dicensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland Charla Houan M01530 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MOLET < Medical Due for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Orona within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No Month Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes X Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 XNo မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗆 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) 36207

j () V State

DHMH 17 Rev 7/2009

Registrar

11119 Rockville Pike, Suite 210, Rockville, MD

20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Thomas C. Militano,

MAR 30

31. Date filed (Month, Day, Year)

Amend #6 & Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EAM Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL **BALTIMORE** RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 08/734/19/34 130-26-7889 75 Yrs. Director NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director or 28a-f sl MD BALTIMORE BALTIMORE 1 🗌 Yes 2 🔀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 3702 DURLEY LANE 21207 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ò Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. WHITE 3 X Widowed 4 □ Divorced Specify. Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE **ADVERTISING** Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ဨ **ISADORE** SIEGEL **ESTHER** BASON t. Page 1 and 2 should by treent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Prinschild) N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTIAAN CORNELLIS SCHILLDT 3702 DURLEY LANE, BALTIMORE, MD 21207 Department of Health Important: If item 27 any injury or other to once. Ob. Place of Disposition (Name of AREMENGTONION CEMPTER)
CHIZUK AMUNO 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗡 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 03/28/2010 BALTIMORE, MD 21. Signature of Juneral Service Livengee 22. Name and Address of Facility SOL LEVINSON & BROS., 18900 REISTERSTOWN ROAD, PIKESVILL<u>E, MD 21208</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ on disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Jause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Dav 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🔀 No ြု 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗀 No death Accident Investigation after deat Director: Suicide 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral Completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Re State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ris Soares		State of N	faryland / De	partme	ent of Health a ate of Death				10 0969				
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		ei unca	- Death		2. Date of Deat		3. Time of Death				
dical Exami		Kris Vergara Soa					Month March 27,		0410 hrs				
,		4a. Facility Name (if not institution, give stree St. Josephs Hospital	t and number)		4b. City, Town, Towson	or Location of Dea	ath	4c. County of Baltimore					
Funeral		Social Security Number 6. Sex	7. Age (In y	s. last birth	nday) If Under 1 Y		lrs, 8. Date of Birt		9. Birthplace (State or				
Director		214-08-7871 15m	2□F 30		Yrs. Months D	ays Hours M	in. 12/03	/1979	Foreign Country) MD				
any		Usual Residence of Decedent  10a. State 10b. County	10c.0	Lity Town	or Location				10d. Inside City Limits				
ž		MD Baltimor		wsor					1 Yes 2 No				
Aaryland 28n-f show 1 at once.	Director	10e, Street and Number			10f. Zip Code	Э	10	g. Citizen of Wha	it Country?				
th the Maryland 23a or 28a-f sho		3 Midcrest Ct.			2128			USA					
ath wit items 2	Funeral	1 Never Married 2 Married	Was Decedent Ever in Armed Forces?		<ol><li>Was Decedent of If Yes, specify Cul</li></ol>	Hispanic Origin? ( ban, Mexican, Puer		14. Race - White,	American Indian, Black, etc.				
fter de I", or	by Fu	3 Widowed 4 Divorced If Yes,	Yes 2 N	0	1 Yes 2	No specify:		Specify: 1	an				
hours a		15. Decedent's Education (Specify only high			Decedent's Usual Occuluring most of working			16b. Kind of Busi	iness/Industry				
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) C	ollege (1-4 or 5+) 2	Sa	les			Retail					
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygeine. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once	S	17. Father's Name (First, Middle, Last)				1B.Mother's Na	ne (First, Middle, N	taiden Surname)					
d be fil fental H narked event,	Be	Roy Soares  19a. Informant's Name/Relationship (Type, P	rint \	1406	. Mailing Address (St	Cora	zon Ver	gara Bar City or Town	State Zin Code)				
AD 2 shot and 1 sand mati	입	Roy Soares/Father			Midcret								
ore, Nes I and of Health If item	77	20a. Method of Disposition  1 Burial 2 Cremation 3 Re	20 movel from State	b. Place o	f Disposition (Name of ory or other place)		Data	000 1	Site on Town Chata				
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify:		Chesa	peake Cr	em. "	2010	Beltsv	rille, MD				
Baltimo permit. Page Department of Important: injury or otl		21. Signature of Funeral Service Licensee	Mo	1585	22. Name and Addr	ess of Facility AF	A/Steph	en D.Lo	hrmann P.A.				
Physician	-0	23a. Part I. Enter the disease, or complication	ns that caused the de	ath. Do no	18717 Gr t enter the mode of dyi	ng, such as cardiad	or respiratory arre	r Balt est, shock, or hear	t Approximate Interval Between Onset and				
/Medical Examiner		failure. List only one cause on each line  Immediate Cause (Final disease a. A		tic	heroin) in	toxicati	on		Death				
Zamier		or condition resulting in death)  Due to (or as a consequence of):											
	ē		(or as a consequence	e of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence	ce of):									
executed an and al - transit		d	23a.P	<del>II.27</del>	,28a-f,per	m,E g902	4/8/10 T	T					
ਲ ਲੋਵ	edic	X UNPENDED X AME	29d per MI	g90	,28a-1,peri 2 4/6/10 T	r			lolivon				
Box 68760, edeath certificate be the artending physici ad for use as the burn defor ation	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Live birth	2		3 Ectopic preg	nancy	23d. Date of d Month	Day Year				
lox 6 eath cert eath cert attendii	sici	1 Yes 2 No 9 Unknown 9	Pregnant at time o	f death 5	Other (Specify)								
that the detached		Part II. Other significant conditions contr	ibuting to death but n	ot resulting	in the underlying caus	se given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?				
S, P.	ed by	Cocaine use; asth	ma				-	2 ✓ No 3					
cords aw requi	Completed						24a. Was a autop	sy pri	ere autopsy findings available for to completion of cause of eath?				
ital Recional The L	S					(D. all. (Ob.	1 Yes		Yes 2 No				
Division of Vital Records, tal or Attending Physician: The law requinrs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the	o Be	25. Was case referred to medical examiner?  Hospita	al: 1 Inpatient 2	✓ ER/O		Other Nur		Residence 6	Other:				
J of \ding Phy	-	27. Manner of Death	Ba. Date of Injury (Month, Day, Year)	28b. 7		njury at Work?		now injury occurre	d				
Sion Attendi death. ctor:	atio	Z Accident investigation	d 3/27/10		3.01 am	Yes 2 No	unk	Name to a second Street to a	as Dural Doute Alumbay City				
Divis pital or At ours after d ieral Direc	Certification:	Suicide o L Could not be determined		at nome, ra ouse	rm, street, factory, offic	ze building, etc.	or Town, S	tate)	r or Rural Route Number, City WSON, MD				
Hospi 24 hou Funer tely fil		29a Certifier 1 Certifying Physician: To	o the best of my know	/ledge, dea			nd due to the caus	e(s) and manner a	as stated				
To the within To the comple	Medical	one) 2 Medical Examiner: On the	ne basis of examination	on and/or ir			d at the time, date						
	Σ	29b. Signature and title of certifier	. 0		i	ense number C.M.E.		3/27/20	(Month, Day, Year)				
		30. Name and Idress of person who complete	eted cause of death (	Item 23a)				3,21,20					
			nt Medical Exar	niner	111 Penn Street,	Baltimore, MI	21201						
St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sig	nature	harle								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#IperPHYS#8perFH, G902, 4/6/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lastwilliam Berkley Thomas 2. Date of Death 3. Time of Death 26<sup>Day</sup> Physician/ Williams Berkley Thomas March 201 gai 2:04 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Nursing Center Towson <u>Baltimore</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs, 9. Birthplace (State or Foreign 8. Date of Birth Age (In vrs. last birthday) **Funeral** Days Hours Min. Feb. 26 87 Director 219-16-9666 <del>2010 V</del>irginia Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🗆 Yes 2 🖺 No Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 617 Cromwell Whye Lane 21111 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Chuffeur 12th Grade Black&Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Berkley Thomas Mary Alice Chatman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Cromwell Whye Lane Monkton, MD 21111 Zilpha Thomas/ Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Green Mount Cem. 4 Donation 5 Other (Specify) 3/27/10 Baltimore, Md 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature Function Ferri 5240 Reisterstown Rd. Baltimore, MD 21215 Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart/ailure. List only one cause on each line. 23a, Part Approximate shock, or heart Interval Between Onset and Death Immediate Cause Final ease or condition Physician of Colon Conc omplications Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate bause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by vasular disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? obstructive phlmonary disease 24a, Was an Jas performed? Yes 2 No after death.

Director: After this certificate ! 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (RNP R149194 March 24,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Grant, 6701 N. (harles Towson, MD 31. Date filed (Month, Day, Year) State 32. Figistrar's Signature Registrar

			For	Pleas	se Type State								I <mark>I Copies</mark> Iental Hy		Legib	le.		
		•	1 - State Registrar					Cei	rtifica	ate of	Death			Reg. No.	20	10	000	9.8
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Exa	amine	er		County Ger		spital				Colum						ward		
Fund Direc			5. Social Security N 276–16–766	55	6. Sex XX M 2□		e (In yrs.	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under Hours	Min.	8. Date of Bi (Month, D Februar	rth ay, <i>Year)</i> y 14,1	921 E	enns	place (State or ntry) Sylvania	Foreign
land	***		Usual Residence of 10a. State	10b. County			10c. Cit	y, Town or Lo	cation							1.	10d. Inside City	y Limits
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er de:	ner m	Funeral	11. Marital Status	a	Arme	Decedent ed Forces?		S. 13.	Was Dec If Yes, sp	edent of Hoecify Cuba	lispanic O an, Mexica	rigin? (Sp ın, Puerto	ecify Yes or N Rican, etc.)	0-		- Ameri White,	can Indian, etc.	
Irs aft	E K	by	1 ☐ Never Marr 3 🛛 Widowed		If Yes	Yes 2□ s, Give or Dates:	INO		1 □Yes	2 <b>x</b> No	Specify	<b>:</b> :			Specify:	Whit	te	
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shoulk nd Me	mat m	ပ	19a. Informant's N		nip (Type. Print	)		19b. Mailir	ng Addre	ss (Street			al Route Num	ber, City o	r Town, S	tate, Zij	D Code)	
alth a	er tra		Robert A.	Thomas	(Son)			7518 7	Water	Lily	Way	Colum	bia, Mar	yland	21046		,	
es 1 a of He fittern	ě l		20a. Method of Dis	position Cremation	2 Demously	from Chata	20b. P	Place of Dispo	osition (A	lame of r other plac	ce)		Date	20c. Lc	cation - C	ity or To	own, State	
t. Pages tment of tant: If it	Jury			5 ☐ Other (Sp		nom State	_ Atl	antic C				3-30-2		Gler	Burn	ie, l	Maryland	
perinii Die, Mai ylailio Z 1 Z 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	any In		21. Signature of Fu	neral Service L	icensee	. 11		W.	2. Name itzke	and Addre	al Ho olls F	ity mes,	Inc.	. M	11	210	, -	
			23a, Part 1, Entert	he disease, or	complications t	beicause	d the deat								yıand	210	Approximate	
> Physic	ian		23a. Part 1. Enter t shock, or nea Immediate Cause	(Final									от тооршинот,				Interval Betw Onset and D	veen
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w requires to been signer	ag pin	ed by											Inknown					
law re	Z sno	Completed									-		24a. Wa		24b. W	ere aut	opsy findings a	available
The The	page	E O							- " -				per 1 🗆 Yes	opsy formed? 2 No	de	ath? □Yes	2 X No	1056 01
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dlng After	Inne	tion	1 Alatural	5 ☐ Pending investig		(Month, Da		Injury	M	28c. Injui Wor	k? lYes 2□	]No	28d. Describe	now injur	y occurred	1		
r Atter	by the	ertification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ot be 28e.	Place of In	jury - At ho	ome, farm, sti	reet, fact	ory, office			28f. Location	(Street ar	d Number	r or Rui	al Route Numi	ber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	Illed In	O	29a. Certifier	Certifyin	g Physician:				th occurr	ed at the ti	ime, date a	and place				ner as	stated.	
n 24 h	Dietery	Medical	(Check only one)	2☐ Medical I	Examiner: On	the basis of manner st	of examina	ation and/or ir	nvestigati	ion, in my	opinion, de	eath occu	rred at the time	e, date and	place, ar	nd due	to the cause(s)	)
To the To the	E00	ž	29b. Signature and	title of certifier	Cm -	MI	\		2	29c. Licens	se number	611	-	29d. Da	te signed	(Month	Day, Year)	
141			30. Name and add	1 dest	1	- 1	٦			DO	062	-24	5	10	lar	2	1, 20	10
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Re	Stat gistra		JI. Date liled (MO)	nth, Day, Year)		32. Regist	rar's Signa	ature back										

DHMH 17 Rev 1/2001

	For State Registrar		State of Marylar		irtment of <i>tificate o</i>		_	giene Reg. No. 2010	09699
Physician		(First, Middle, Last)	Thatan			0	2. Date of De Month	Day Year	3. Time of Death
/Medical Examiner	4a. Facility Name (I	f not institution, give s	treet and number)	don	0 1	or Location of Dea	2	4c. County of Death	
Funeral Director	5. Social Security No. 2/4-20 ·	umber 6. Sex	3 /1/	last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hr	8. Date of Bir	th 9. Birth	place (State or Foreign
70	Usual Residence of 10a. State		1 - 9	ty, Town or Loc	cation		700	0 //=3	10d. Inside City Limits
the Mary 28a-f sh retified	MD 10e. Street and Nun	nber		Balt	10f. Zip Code			10g. Citizen of What Cou	1 XYes 2 □ No ntry?
fter death with the Mar fter death with the Mar filems 23a or 28a-f sh funeral Director	2705	Kosl	4n Aven 2. Was Decedent Ever in U	ue		2/2/6 Hispanic Origin? (	Specify Voc or No	USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Event Inc. its traumatic and once.  To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married	Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	l II	Yes, specify Cu	ıban, Mexican, Pue	rto Rican, etc.)	Black, White,	
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;, IVIGII and 2 sh ealth and n 27 is rr er traurr	Ann Ca	ame/Relationship (Type Crolyn Fo	avorite	19b. Mailin	- 11/-	1-1-11	Rural Route Numb	ner, City or Town, State, Z Riverview	FL 3356
Pages 1 nent of H nt: If iten		oosition <b>/</b> ☐ Cremation 3 ☐ Ro 5 ☐ Other <i>(Specify)</i>	emoval from State	cemetery, crem	sition (Name of natory or other p		Date - 2010	20c. Location - City or T	own, State
permit. Departn Importa any inju	21. Signature of Fu	neral Service License		22	Name and Add	Facility Wee	2-2010 ne Fur Nation	neral Ser	vices (21229)
	23a. Part 1. Enter the shock, or hea Immediate Cause (	rt failure. List only on	cations that caused the dea e cause on each line.	th. Do not ente					Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:	IF FEMALE:  23b. Was decedent in the past 12  1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3 ⊑	Ectopic pregna Other (specify)			23d. Date of deli Month	very Day Year
signed by d be detact	Part II. Other signif	icant conditions con	tributing to death but not res	sulting in the ur	nderlying cause (	given in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pro	
The law required that the speed is page 2 should							24a. Was	an 24b. Were au	opsy findings available
ding Physician: The I h. h. h. h. h. treat this certificate hr funeral director, page times. To Be Comition: To Be Comition:		red to medical	29			26. Place of Do	perfo 1 □ Yes eath (Check only)	ormed? death? 2 No 1 ☐ Yes	2 No
Physici Physici er this ce eral direc	1 Yes	140	ospital: 1 Inpatient 2 2	28b. Time of	1 3 L DOA	ther: 4 \sum Nursing	Home 5 ☐ Res	idence 6 Other (Spec	ify)
tal or Attending F rs after death. ral Director: After led in by the funer. Certification:	✓ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not be	(Month, Day, Year)	Injury	M 1	□Yes 2□No		Street and Number or Ru	mt Pouto Alumbar
oital or A urs after aral Directilled in by		determined	28e. Place of Injury - At h building, etc. (Speci				City or To	wn, State)	
o the Hosp Ithin 24 hou orthe Fune ompletely fi	29a. Certifier (Check only one)	2∐ Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	vestigation, in m	y opinion, death oc	ce, and due to the curred at the time	, date and place, and due	to the cause(s)
To viti	29b. Signature and	title of certifier	Was		1 4	rse number		Mark 26	, Day, Year)
10	30. Name and addre	ess of person who con	mpleted cause of death (lie	m 23a) (Type, I	Print)	Worth	west	Hospital	
State Registrar	31. Date filed (Mont	TAR 30 20	32. Registrar s Sign		ha del				

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of	Marylan	•	artment of tificate of				giene Reg. No.	20.10	00700
Physicia	in/	1. Decedent's Name (First, Middle	, Last) CEAGUE						2. Date of Dea Month MARCH		20 <sup>Y</sup> Î	3. Time of Death
Medic Examir		4a. Facility Name (if not institution,		ner)		4b. City, Town,	or Location	n of Death	PIARCII		ounty of Death	
Exami		Southern Maryla				Clint				1	ince Ge	
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. I		If Under 1 Yea Months Days		er 24 Hrs. Min.	8. Date of Birt	h v. Yearl	9. Birtl	nplace (State or Foreign
Director		579-44-9557 Usual Residence of Decedent	T L W Z LAT	80	Yrs.		<u> </u>		Nov. 5	1929	)	DC
and show	ğ	10a. State 10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
Maryl 28a-f otified	irec	DC		Was	shingto	n						1X Yes 2 ☐ No
h the	a D	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Cou	untry?
ms 2.	Funeral Director	1100 46th PL.	SE 12. Was Deced	ent Francia III	C 112 V		019	wining (Con	sife Von av Na		USA	
or ite	by Fi	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Ford	ent Ever in U.s :es? 2 🎮 No		Vas Decedent of Yes, specify Cul			Rican, etc.)	14	. Race - Amer Black, White	
urs afte	edk	3 XWidowed 4 Divorced	If Yes, Give Year or Date		1	☐ Yes 2 🔀 N	lo Specif	fy:		Sp	ecify: Bla	ack
"at hou	ple		t's Education st grade completed)		(Give I	ent's Usual Occu	during mo	ost of worki	ng	16b. Kind	of Business I	ndustry
ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4	l or 5+)		ONOT use retired ency Exa				Burea	au of F	Ingraving
iled w I Hygi other	Be	17. Father's Name (First, Middle, L	ast)		Ouric	леу ша	1		e (First, Middle,			624726
d be f denta Menta arked aric ev	욘	George Robert C	[urner				Row	ena I	sabelle	Snov	vden	
shoul shoul and l		19a. Informant's Name/Relationsh	ip (Type, Print)		1	g Address (Stree						
and 2 Health em 27 ther t		Cheryl B. Green 20a. Method of Disposition	ne-Daughte			Carrico	Mill:				Le, MD.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🗆 Burial 2 🖾 Cremation		State C	cemetery, cren	sition (Name of natory or other pl			Date		ation - City or 1	
mit. Partme vartme oortan injung	1	4 ☐ Donation 5 ☐ Other (S  21. Signature of Funeral Service L		Met		an Crem						VA.
Depariment Department on the once.		Victoring	1. Woo	ds		arshall 308 Suit			Suitlar	mary d, Mi	yland D. 2074	16
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that ca	used the deat	h. Do not ente	r the mode of dy	ing, such a	s cardiac o	r respiratory an	est,		Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition		la ba	mis							Onset and Death
Medical Examiner		resulting in death)	Due to (o	r as a consequ	uence of):							
	Je.	Sequentially list conditions, if any, leading to immediate	b. Dan to for	r an a consect	uanda efi:						20	
d ried ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury										
te be executed lysician and le burial-transi	EX	that initiated events resulting in death) Last	Due to (o	r as a consequ	uence of):							
eath certificate be executed attending physician and for use as the burial-transit	dical	'	d									
ertifica ding p	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregna	ıncv					00	d Data of dati	
atten atten	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Bi 4 ☐ Pregna	irth 2 🗌 Feta ant at time of o	al death 3	Ectopic pregnal Other (specify)	ncy			23	d. Date of deli Month	Day Year
the de	hys	g Unknown	g 🗌 Unkno	wn								
s that gned	by	Part II. Other significant condition	ns contributing to dea		Hemod		given in Par	rt I.				the cause of death?
een sig	eted	enviolinge Re	na outen	emi	yengu	wy vs			1 📙			bably 4 Unknown
he law rette has b	Completed								24a. Was autop perfo 1 \(\sime\) Yes		prior to c death?	opsy findings available ompletion of cause of
sian: T	Be C	25. Was case referred to medical examiner?	Av. s===					eath (Check		Z)EJ ((O)		
Physic this or	<u>ا</u>	1 Yes 2 No 27. Manner of Death			ER/Outpatien	t 3 🗆 DOA			me 5 🗆 Resid			(y) .
ding l	cate	1 Natural 5 Pendin	9	, Day, Year)	injury	28c. Inju wo M 1		_ 1	28d. Describe h	ow injury o	ccurred	
Atten ar dear ector: by the	Certificate:	2  Accident Investig 3  Suicide 6 Could r 4 Homicide determi	not be 28e. Place o	f Injury - At ho	me, farm, stre	et, factory, office					lumber or Rura	al Route Number,
tal or rs afte	Ce		building	g, etc. (Specify	′)				City or Tow	n, State)		
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 I Medical E	Physician: To the best xaminer: On the basis Nurse Practioner: To	of examination	n and/or invest	igation, in my opir	nion, death	occurred at	the time, date a	nd place, ar	nd due to the ca	ause(s) and manner stated.
vith to the		29b. Signature and title of gortife	her	in	0	29c. Licen		12.0			signed (Month,	
		30. Name and address of person v	vho completed cause	of death (Ita-	23a) /Tuno D		055					6,2010
		Richard Palme	MD 1328				#31	0	Washin	, hin.	DC 20	032
Sta Registra		31. Date filed (Month, Day, Year)		gistrar's Signar						0		
ricgioti		MAR OUZUIU	Mun	C. 13	CA TOTAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011

			For State Registrar	State of Maryland		artment of F tificate of D		-	giene Reg. No. 🤈 🎧	l I n	0070
	Physicia		Decedent's Name (First, Middle, Last)  WYSE  S	TAYLOR	SR	· · · · -		2. Date of Dea	From 10	O <sup>Year</sup>	3. Time of Death 5 25A M
	Medic Examin		4a. Facility Name (if not institution, give stre FREDERICK MEMOR			4b. City, Town, or FREDE		1	4c. County FREDE	of Death	<del></del>
	Funeral Director		=11 07 3307 II	M 2 □ F 7. Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da JUN 27	h v, Year) 1917	9. Birthp Count Vir	olace (State or Foreign try) ginia
	Maryland 28a-f show lotified at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Carroll	10c. City	, Town or Lo	Mt. Airy				1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	s 23a or nust be r	Funeral C	10e. Street and Number 485 Watersville Ro	oad		10f. Zip Code	771		10g. Citizen of V USA		itry?
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me fical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cubar		pecify Yes or No- o Rican, etc.)	Blac	e - Americ ck, White, e : Whit	etc.
215-	iin 72 ho ie. han "nat	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of wor	king	16b. Kind of B	usiness Inc	dustry
d 21	led with Hygien other the	as I	17. Father's Name (First, Middle, Last)	,	Busi	ness Owne		ne (First, Middle,	Lawn E		nent
ylan	uld be fi I Mental narked natic ev	욘	Robert Taylor				Unk.				
Mai	d 2 shot alth and 27 is n er traur		19a. Informant's Name/Relationship (Type, Richard Taylor/son	Print)		g Address (Street a Jennifer		ral Route Numbel kesville	-		Code)
Baltimore, Maryland 21215-0036	. Page 1 an ment of He tant: If iten iury or oth		20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	mayal from Ctata Ce	lace of Dispo	sition (Name of natory or other place <b>Cremation</b> Se	a)	Date	20c. Location - Sykesv	City or To	
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee	nuld	Ha P	Name and Addres Right Fun O. Box 1	s of Facility eral Hom 95 Svkes	e & Char ville. N	pel. P.A ID 21784	(410	)-795-1400)
	Physician Medical Examiner		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ause on each line. INTRACR  Due to (or as a conseque	n. Do not ente	r the mode of dying	g, such as cardiac				Approximate Interval Between Onset and Death
0	ificate be executed g physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a conseque	епсе оп: 	ERY DISEA	SE				
. Box 68760	ath cerl attendir for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy	/		23d. Da Mo	te of delive	ery Day Year
ds, P.O.	v requires that the de been signed by the should be detached	ğ	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	nderlying cause give	en in Part I.				e cause of death?
Division of Vital Records,	'sician: The law rec s certificate has bee lirector, page 2 sho	Completed				· .		24a. Was a autop perfor	rmed?	Were autoporior to cordeath?	osy findings available impletion of cause of
/ital	Physician: The lav r this certificate has ral director, page 2		25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hos	pital: 1 🏿 Inpatient 2 🗆 E	EB/Outpation	Otho	ce of Death (Che	ck only one)	C \(\tau\)	(014.)	
on of	ending Phy eath. or: After thi he funeral o	Certificate: T	1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work?	at		ow injury occurre		
Divis	tal or Attend rs after death al Director: A ed in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide a determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Director Completed filled in b	Medical	(Check 2 \( \sum \) Medical Examiner:	n: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or invest	igation, in my opinior	n, death occurred a	at the time, date a	nd place, and due	to the cau	se(s) and manner stated
	To the withing the total community of the tot		29b. Signature and title of certifier	M·D.	number 910		3/24/20		Day, Year)		
			30. Name and address of person who comp Pratima Pandey	pleted cause of death (Item 2 400 W 7th S			ick, Md.	21701			
	Stat Registra	e ar	31. Date filed (Month, Day, Year) ARR 3 0 2010	32. Registrar's Signatu	park				-		

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For		State o	of Marylan	-			alth and N	∕lental Hy	giene	9	20700
		State Registrar				Cer	tificate	of De	ath		Reg. No	.ZUIU	09/02
Physicia Medic		Decedent's Nam	ie (First, Middle	Hiroshi	Taniı	ıchi				2. Date of De Month March	25°	, 20 Year	3. Time of Death 12:05 P M
Examin		4a. Facility Name (if			nber)				cation of Death			c. County of Death	
/ 		4825 Mon 5. Social Security N		Lane 6. Sex	7 Ago/In.um I	not birth dou	If Under	Bethe	esda f Under 24 Hrs.	O Data of Di		ontgomer	<u> -                                     </u>
Funeral Director		214-48-60	006	1 X M 2 □ F	7. Age (In yrs. I.	Yrs.	Months		Hours Min.	8. Date of Bit (Month, De April	tn 13, Ye <i>ar)</i> 13,		nplace (State or Foreign Intry) an
ind ihow	'n	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Maryla Ba-f s tified	rect	Maryland	Mon	tgomery	Ве	thesda							1 🗆 Yes 2 🄀 No
th with the Maryland ms 23a or 28a-f show must be notified at	Ö	10e. Street and Nur					10f. Zip (					itizen of What Cou	
ith wit	Funeral Director	4825 Mo	ntgomer		dent Cres in 110	2 40.1		0814	ania Osiaina (Car	aif . Vaa an Na		ted Stat	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	2	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☒ Widowed</li></ul>		Armed Fo	2 💢 No e	ŀ	f Yes, specif	y Cuban, N	anic Origin? (Spe Mexican, Puerto Spec <i>ify:</i>	ecity yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: As	
2 hour "natu edical	plet	(Spe		it's Education st grade completed)		16a. Deced	lent's Usual	Occupatio	on ing most of work	ina	16b. F	Kind of Business I	ndustry
thin 7; ene. than he Me	Completed	Elementary/Sec		College (1	-4 or 5+)	life. Do	o NOT use i earch	etired)			Fod	leral Gov	vornmont
lled wi I Hygir other ent, t	Be	17. Father's Name (	(First, Middle, L			Rese	Earch		8. Mother's Nam	e (First, Middle	_		ermiene
d be fi Vental arked atic ev	욘	Seijuro	Taniu	hi					Otsue	Maeda			
shoul		19a. Informant's Na					-					r Town, State, Zip	
and 2 Health em 27 ther t		Erie Ta  20a. Method of Disp		/ Daughte		14309 Place of Dispo			<del></del>			ocation - City or	ryland 20905
t. Page 1 tment of tant: If it ijury or o		1 🕅 Buriai 2 4 ☐ Donation	☐ Cremation 5 ☐ Other (S		State C	lawn Mer	natory or oth norial	er place) P <b>ark</b>	i	h <sup>ate</sup> 29,	Roc	kville,	Maryland
permi Depar Impor any ir		21. Signature of Fu	ineral Service L	Mynist	M01:	305 R	bert A. 57 Wisc	Address Pump consin	hrey Fune Avenue,	ral Home Bethesda	/Beth , Mar	nesda-Chevy cyland 208	/ Chase, Inc. 14-3501
Physician/			rt failure. List o (Final	complications that only one cause on ea			er the mode	of dying, s	such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death 22 Months
Medical Examiner		resulting in death)	511	d	or as a consequ								
sit sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	b. Due to	or as a consequ	uence of):							
cate be executed physician and s the burial-transit	Exar	that initiated event resulting in death)	s	c. Due to	or as a consequ	uence of):							
e be e iysicia ne buri	dical		+	d									
tificat ing ph as th		IF FEMALE:		1									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent in the past 12 I 1  Yes 2 9  Unknown	months?	1 Live	come of pregna Birth 2  Feta nant at time of c nown	al death 3	Ectopic pr Other (spe					23d. Date of deli Month	very Day Year
uires that t signed b lid be deta	ed by P	Part II. Other signif	ficant conditio	ns contributing to d	eath but not res	sulting in the u	nderlying ca	use given	in Part I.				the cause of death?
aw requas beer 2 shou	nplete									24a. Was	nsv	prior to c	opsy findings available ompletion of cause of
: The l										perfo	ormed? 2 X N	death? lo 1 🗌 Yes	2 🗌 No
sician certifi rector	Be	25. Was case referred examiner?		Hospital:			F1 -	Other	of Death (Checi				
Phys er this eral di	e:	27. Manner of Deatl		28a. Date		28b. Time of		. Injury at		ome 5 X Resi 28d. Describe		6 Other (Special formula of the control of the cont	fy)
arth. or: Afte	licat	1 X Natural 2 Accident	5 Pendin Investig	gation	th, Day, Year)	injury	M	work?	s 2 🗆 No				
al or Atte s after de il Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could i determ	ined 28e. Place	of Injury - At hong, etc. (Specify		eet, factory,	office		28f. Location ( City or Tou		nd Number or Run e)	al Route Number,
he Hospit in 24 hour ne Funera pleted fills	Medical	(Check 2	🛚 🔲 Medical E	Physician: To the bas xaminer: On the bas Nurse Practioner:	is of examination	n and/or invest	tigation, in m	opinion, o	death occurred a	t the time, date:	and place	e, and due to the c	ause(s) and manner stated.
To the come come	_	29b. Signature and	title of certifier	0			29c.	icense nu				ate signed (Month,	
		30. Name and addre	ress of pareon	who completed caus	e of death (Item	23a) (Tupe =	Print)	D296	575		Mar	ch 26, 2	010
0 <		Ralph Bo	ccia, N	1.D. 642	,	, , , , .	,	#410	0, Beth	esda, M	ary1	and 2081	.7
Stat Registra	-	31. Date filed (Mont	MAR 3	I A ARAB	egiatrar's Signa	ture .	bank	9					
				•		. 1	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year С. Voshe11 6,2010 :00AM as 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death timor N/A8. Date of Birth (Month, Day, Y Sept. 6, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) Year) 1914 Min. Days 1 □ M 2 🖺 F Months Hours Sept. 95 Yrs 216-05-0295 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Baltimore Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane #7112 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Casimir Masenduke Veronica Blumas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Palencar/ Daughter 12 Liberty Ridge Court, Owings Mills, Maryland 21117 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery: 2010 Baltimore, Maryland 21. Signature of Funeral Service License Amanda Heaston 22. Name and Address of FacilityMacNabb Funeral Home, P.A. BO1 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 10 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29c. License number

March 26, 2010

ane, Bultimore, MD 21228

**Physician** Examiner o Records, Division of Vital To the Hospitai

Physician

Examiner

Director

Funeral

2

Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination is used by notified at

filed within 72 hours after death with

Hygiene.

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Pages 1 and 2

Department of Health ar Important: If Item 27 is any injury or other trauonce.

/Medical

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page 2

funeral

After this certificate

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To the Funeral I

completely filled

physician

Baltimore, Maryland 21215-0036

/Medical

be or Attending Physician;

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Pay,

29b. Signature and title of certifier

(Check only one)



Mai

and manner stated

30. Name and address person who complete cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Emily Duroska Vesely March 19. 2010 6:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 126 Boxthorn Road Abingdon Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖬 F Yrs 2, 132-24-2908 1922 Czechoślovakia Director 88 Feb. Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2X No Maryland Harford Abingdon 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? items 23a or Funeral USA 20 Boxhill Parkway South 21009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. filed within 72 hours after 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married ٥, Baltimore, Maryland 21215-0036 1 ☐Yes 2€ No Specify þ 3X Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 is marked other I any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Anna (nmn) Dzuroska Matthew (nmn) Duroska ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 126 Boxthorn Road, Abingdon, Maryland 21009 Richard C. Vesely / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp.: 3-30-10 Towson, Maryland 21. Signature of Funeral Service Lice McComas Funeral Home, P.A. Mark 1317 Cokesbury Road, Abingdon, Maryland 21009 so the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, early line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Metastatio Immediate Cause (Final **Physician** mon this disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Hospital or Attending Physician: The law requires cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 0 Division of Vital 1 ☐ Yes 2 No 1 TYes 25. Was case referred to medical Other: 4 Nursing Home 5 Nursing Home 6 Nother (Specify Residence Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2√No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45530 03-19-2010 aun

Registrar

State

602, SAtwood road,

Belair 20110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

S. SIVASAILAM

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

Provided Name First Move Laid    Security Name in Form Move Laid   Security Name in Form Move Laid   Security Name in Form Move Laid   Security Name in Form Move Laid   Security Name in Form Name First Name Fi				For State	State of	f Marylan	-	artment of		and M	lental Hy	giene	0010		post
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Registrar MAR 3 0 2010 September 19. April 19.		Stat Registra		31. Date filed (Month Pare 3	ate filed (Months Par 7 e 3 0 2010 32. Jegistrar's Signature). January										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 3:00 A.M March 26, 2010 Julia LaRue Wagner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home
5. Social Security Number | 6. Sex Manchester
1 Year | If Under 24 Hrs. Carroll If Under 1 Yea 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2000F Director July 14, 1918 Maryland 215-14-2225 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at MXYes 2 □ No Director Maryland Manchester Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21102 3335 Locust Street America Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2XXNo
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 1 □Yes 2XXVo Specify: þ XXWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Je filed wh. اما Hygiene. م**r than"** Elementary/Secondary (0-12) College (1-4or 5+) 10th Winding Department Black and Decker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be finand Mental F Be Edith Lydia Melvina Frock George V. Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If item 27 Is Arnold E. Wagner (Son) 500 Plum Tree Road, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 30, injury or permit. Page Department o Important: If a 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 New Lutheran Cemetery Manchester, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Signature of Functal Service License 3296 Charmil Drive, Manchester, Maryland 21102 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 091985HP **Physician** disease or condition resulting in death) /Medical Due to (or as a pensequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and that initiated events resulting in death) Last physician at the burial-t Due to (or as a consequence of): Physician/Medical as IF FEMALE use yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X No 3 Probably 4 Unknown 1 □ Yes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. completely filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

certificate be executed Box 68760, P.O. I of Vital Records, Hospital or Attending Physician; Division

Saltimore, Maryland 21215-0036

To the I within 2

State Registrar panswita, MD

29c. License number

29d. Date signed (Month, Day, Year)

51705 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANSURIYA 2111 Harover

and manner stated.

Pike

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hampstead

, MD 21074

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

320 Registrar's Signature MAR 30 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Gloria Wilson Month 12:15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Season's Hospice Randallstown If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral 7. Age (In vrs. last birthday) Hours Min (Month, Day, Year) 2 01 2 1 M 2 XF 87 Director 214-22-1457 MD Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 X No MD Baltimore Owings Mills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21117 4700 Coyle Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Examiner Armed Force Black, White, etc. 5 1 Never Married 2 Married þ 1 ☐ Yes 2 💢 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. "natural" 3 XWidowed 4 Divorced Completed 20 the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Socia Security Adm. Program Asalyst 2th grade na other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russel Sewell <u>Kathryn Young</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau Croydon Road, Baltimore, Md 21207 Howard Wilson-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/25/10 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Baltimore, Md Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Alsheimers Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Exam requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Live Birth 2 Live Birth Pregnant at time of death Month Year 5 Other (specify) the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 000 5 7 4 6 5 29d. Date signed (Month, Day, Year)

State Registrar ns Ryapalnem D

Rajupakkimo

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

DHMH 17 Rev 7/2009

ark

Smith AV. S. 203,

3/24/10

Bal hmore, MD. 212179.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 09708

uliy Anson vvnite			- For State	or Maryland / Dep Ce	ertificate of De				, 55100			
Physician lical Examine			Registrar 1. Decedent's Name (First, Middle,La		TIT		2. Date of Death		3. Time of Death			
		ner	Jully Hnson		111_		March 26,	2010 4c. County of Death	2128 hrs			
			4a. Facility Name (if not institution, gi Sinai Hospital	ve street and number)		ty, Town, or Location of De Itimore	aur	40, County of Beatty				
Funeral			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (St.									
Director			215-96-07-92 12 M 2 F 55 Yrs. Months Days Hours Min. 01/15/1955 Country) V F									
	ages I and 2 should be filled within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-5 show any other traumatic event, the Medical Examiner must be notified at once.	J.	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City L									
7			MD Baltimore									
i		Director	10e. Street and Number	, ,		Zip Code	10	g. Citizen of What Cour	ntry?			
4			2212 Lynhu		e	21216	10 7 14	USA	can Indian, Black,			
1		Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever in the Armed Forces?  1 Yes 2 No		edent of Hispanic Origin? ecify Cuban, Mexican, Pu		White, etc	L L L L L L L L L L L L L L L L L L L			
4		by F.	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:		2 No specify:		Specify:	ack			
5			15. Decedent's Education (Specify of Elementary/Secondary (0-12)	conly highest grade completed)  College (1-4 or 5+)		ual Occupation (Give kind working life. DO NOT use		16b. Kind of Business/I				
)36  }		Completed	Elementary/occordary (o 12)	lvr	Contro	ctor			ement			
215-0036	Hygier I other the M		17 Eather's Name (First, Middle, Las	111 -		18.Mother's Na	me (First, Middle, M					
2121	Mental marke event	To Be	19auInformant's Name/Relationship (	Type, Print)	19b. Mailing Add	ess (Street and Number	oc Rural Route Num	ber, City or Town, State	, Zip Code)			
MD ;	h and N 27 is n matic	-	71 1 -11	oson (Mother)	) 2205 N	1 11 4		timore m	D 21216			
	permit. rages I and 2 should be lifet with Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		20a. Method of Disposition  1		Place of Disposition ( crematory or other place		Date	20c. Location - City or	4			
Baltimore,	나의물등		4 Donation 5 Other Specif	y: 16		Forest 4	1-1-10	Chings 1	Nills, MD			
Ball	Departn Importi injury (	Ų	21. Signal re of Funeral Service Lice	. Ne one		and Address of Facility	reene tu	neral er	vices			
Phy	Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
	ledical aminer		failure. List only one cause on each line.  Immediate Cause (Final disease a Narcotic and alcohol intoxication  Between Onset and Death									
			or condition resulting in death)  Due to (or as a consequence of):									
	ı t	iner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Cause. Enter Underlying Cause									
1		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
No.	recuted n and - transit		X UNPENDED 5 per fh g901 3-31-10 vt 23a,27,28a-f,per ME g902 4/15/10 TT									
90,	ng Physician: The law requires that the death certificate be externed in the sentificate has been signed by the attending physician ineral director, page 2 should be detached for use as the burial	hysician/Medical	X UNPENDED  IF FEMALE:	23a, 27	28a-f,per	ME 2902 4/1	5/10 TT	23d. Date of delivery	,			
6876			23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of c	2 Fetal de		egnancy	Month [	ay Year			
Box 68760,			1 Yes 2 No 9 Unknow	· L	death 5 Other (	Specify)						
P.O.		۱-	Part II. Other significant conditions	contributing to death but not	resulting in the under	ying cause given in Part I.	01	bacco use contribute to				
S, P		ed by					1 Yes	2 No 3 Prot	topsy findings available			
ord		ompleted					autop	sy prior to o	completion of cause of			
Re		ပ	25. Was case referred to medical			26 Place of Death (Cho		2 No 1 Ye	es 2 No			
/ital		o Be	examiner?	Hospital: 1 Inpatient 2	✓ ER/Outpatient 3	- Iother -	ursing Home 5	Residence 6 Other	~			
ot		$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	1	now injury occurred				
Division		catic	2 Accident Investiga	3/26/2010 28e. Place of Injury - At	unk	1 Yes 2 No		Street and Number or Ru	ral Route Number City			
Divi		ertification:	3 Suicide 6 A Could no determin	t De home		tory, ombo banding, oto.	2212 Lyn	tate) ndhurst Ave	Baltimore,			
.)		Medical Ce	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
			29b. Signature and title of certifier	and manner stated.		29c. License number		29d Date signed (Mo				
			O.C.M.E. March 27, 2010									
30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
	V	tate	31. Date filed (Month, Day, Year)	4			201					
	Regis		MAR 3 0 2010	32. Registrary Signa	parke							

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COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death Month **Evelyn Mae Wessel** Mar 27, 2010 1:55 PM Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson **Baltimore** Gilchrist Hospice Center Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) Sep 11, 1936 Days 1 🗆 M 2 🖳 F MD 215-34-0038 73 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked theyer than "natural", or items 23a or 28a-f sho any injury or or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director Laurel MD Howard 1 Yes 2 TNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20723 U.S.A. 8525 Murphy Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Contractor School System Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Britton Carroll Mullinix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5476 Cedar Lane; B-4, Columbia,, MD 21044 Carol L. Wessel-daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 01, 2010 Fulton, MD St. Paul's Lutheran Cemetery 4 ☐ Donation 5 ☐ Other (Spedify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ture of Funeral Service 4 Munterles Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Direccontic disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or linjury To the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes Records, 24b. Were autopsy findings available prior to completion of cause of 24a Was an cate has , page 2 s performed? Yes 2 No 1 Yes 2 No certificate **Division of Vital** funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Dice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this ( 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending work? 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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		_	1 - State of Maryland / Department of Health and Mental Hygier Certificate of Death							g. No.2 ()	2010 00710				
	Physicia Medic									2. Date of Death 3. Time of Death Month 23 2010 1859 M					
	Examir	ner			n, give street and numb hapel Rd.		4b. City, Town, or Location of Death  Mt. Rainier			of Death		4c. County of Death Prince Georges			
	Funeral Director		5. Social Security Number 6. Sex 7. Ag		7. Age ( <i>In yr</i> s	e (In yrs. last birthday) If Under 1 Ye				9. Birthplace (State or Foreign Country) DC					
			Usual Residence of 10a. State				ty, Town or Lo	action		1		1733	L		
	Aarylan 8a-f st tified a	Funeral Director	MD	ĺ	e Georges		. Rain:							0d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	th the Na or 2	al Di	10e. Street and Nur	nber		-		10f. Zip Code			10	g. Citizen of V	/hat Coun	itry?	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Timportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	nner	3001 Qu	hapel Rd.	1 Rd. #114 2. Was Decedent Ever in U.S.		20712 13. Was Decedent of Hispanic Origin? (Spe			o or No	USA				
920		2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced  Armed Forces 1 🖫 Yes 2⁴ If Yes, Give Year or Dates			ces? 2 23 No		If Yes, specify Cuban, Mexican, Puerto Rica  1 ☐ Yes 2 ☒ No Specify:			etc.)		14. Race - American Indian, Black, White, etc.  Specify: Black		
15-0	"natu edical	Completed	15. Decedent's Education 16a. Decedent's Usual O (Specify only highest grade completed) (Give kind of work d				kind of work done	during mos	st of working	1	6b. Kind of Bu	Kind of Business Industry			
21215-0036	oe filed within 7 intal Hygiene. ced other than c event, the Mi		Elementary/Sec 12th	College (1-	4 or 5+)	life. D	life. DO NOT use retired Postal Clerk		)		US Post Offic		fice		
Maryland		To Be								ne (First, Middle, Maiden Surname)					
ary	hould I and Me s marl umati		Leonard Francis Warker, 51.							Judith Martin  Rural Route Number, City or Town, State, Zip Code)					
Σ	nd 2 sleath a ealth a m 27 i				, Sr So	n		2 Ketteri							
Baltimore,	Page 1 ar nent of H ant: If iter ury or oth		20a. Method of Disp 1 XBurial 2 4 Donation	☐ Cremation	3 Removal from S	State (	cemetery, cren	sition (Name of natory or other pla Cemetery		Date 3-31-20		oc. Location - Suitlar	•		
Balt	Depart Depart Import any inj		21. Signature of Fu	geral Service	Licensee 1	.11	) <sup>2</sup> 1	narsing 1 di	ss of Facili	Weral Ho	ome of	Maryl	and		
		П	23a. Part 1. Enter t	he disease, o	complications that ca	aused the deat		4308 Suit er the mode of dyir				.d,MD. :	20746	Approximate	
8	hysician/		Immediate Cause (	Final			scle	rotic	Hyp	erten	oive	Hear	TDi	Interval Between Onset and Death	
	Medical Examiner	J.	resulting in death)  Sequentially list co	nditions,	b. ———										
ŁY	e executed cian and urial-transit	Examiner	if any leading their cause. Enter Unde Cause (Disease or that initiated event	rlying iinjury	С.	or as a conseq									
	death certificate b the attending physic ad for use as the b	ज													
Box 68760		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   1   Ves 2   No   1   Ves 2					су			d. Date of delivery Month Day Year				
P.O.	es that the des signed by the s I be detached i	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of								e cause of death?				
ds,	rate has been sign page 2 should be	ted b									pably 4 Unknown				
Records,		Completed by									4a. Was an autopsy performed Yes 2	ed? d	Vere autoprior to cor eath?	osy findings available mpletion of cause of	
tal	nysician: The his certificate director, pag	Be	25. Was case referre		dical 26. Place of Death (Check only one)										
of Vital	tending rings leath. tor: After this the funeral di	<u>ان</u>									)				
ion o		tificate	1- Natural   5   Pending   (Month, Day, Year)   injury   work?   1   Yes 2   No   No   No   No   No   No   No												
Division	lo the Hospital or At within 24 hours after of To the Funeral Direct completed filled in by														
h :	lo the Hospital within 24 hours To the Funeral   completed filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	o viti		29b. Signature and	title of certifie	en Sh	3 to	00	29c. Licens		5927	296	d. Date signed	(Month, L	0ay, Year)	
			30. Name and address		who completed cause	of death (Item	23a) (Type, F	Print)	Drin	ry ch	eve	·lu	un	6, 200 flow of	
	Sta Registr	te	31. Date filed (Mont		32. Re	gistrar's Signa	iture			J -		11			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10d.perFH.G901.3/30/2010 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician M00D 11:00 PM March 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSBITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2 F 56 216-60-6433 19, 1953 Director Nov Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 Is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more. 10c. City, Town or Location 10b. County 10d. Inside City Limits TATES 2 No Director MD Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 432 Seward Ave. 21225 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Electrical Construction Misc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Nathaniel Wood Lena Marie Amos ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Wood /Brother 4405 Ritchie Highway Brooklyn, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mar 27 Beltsville, Maryland Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Normal Addission of Addity Funeral Alternatives MO1585 necisor 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia 10 Days /Medical Due to (or as a consequence of) Examiner Congestive Heust Sequentially list conditions Due to (or his a consequence of) Examiner day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed CANCER Sophagew attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 1☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) MD RES DOI March, 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 3001 S. Hanover Yasir Hamao 21225 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 30 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24<sup>Day</sup> Month 3 Physician/ 2010 7:41 A Joseph Jackson Willett Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore 906 Eastwind Road Towson Social Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. CA'Tabama 7/257 P931ar 102-20-4248 78 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Eastwind Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Advertiser Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Jackson Willett, Jr. Mary Knox Fitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Willard Willett /Wife 906 Eastwind Road Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Durial 2 X Cremation 3 D Removal from State Hilltop Serv. Corp. 3/26/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examil To the Hospital or Attending Physician: Telaw equires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Fecords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 🗌 No 1 Tyes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director, After this of a political places of the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 7334-00 24/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6301 N. Charles Street, Suite 5 10111 Iglehart Iredell W. .M.D Baltimore, Maryland 21214 32. Registrar's Sj State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Lee Wilner 6:40AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN SEASONS HOSPICE AT NORTHWEST HOSPITAL Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛚 F Davs Min. 0571971919 Director 086-10-9011 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c, City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Directo ms 23a or 28a-f s must be notified 1 Yes 2 No MD BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21117 4730 ATRIUM COURT, #311 "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 3 Nidowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
SOCIAL SECURITY Medical 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed when the Department of Health and Mental Hygiene. Important: If item 27 is marked other than Important: If item 27 is marked other than West Fraumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) ADMINISTRATION ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JACOBS** ROSE SALTZMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3905 ESGARTH WAY, OWINGS MILLS, MD 21117 LARRY WILNER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 03/28/2010 REISTERSTOWN, MD BALTIMORE HEBREW Donation, 5 - Other (Specify) SOL LEVINSON & BROS., INC. uneral Service Lic 22. Name and Address of Facility 21. Sign 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause of peach line. 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death End Stage Alsheimers Dementia Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 124 hours after death.
124 hours after death.
e Funeral Director, After this certificate has been signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be Other (Specific) 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ျ 28a. Date of injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MS RajupameM. D

N.S. Rajupalise MD

MAR 3 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2835 Smith AV - 5. 203 - Baltimore, MD. 21209

DOUS7465

29d. Date signed (Month. Day, Year,

3124/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 534 PLDRIDGE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4820 Riverside Drive Galesville Anne Arundel Social Security Number If Under 1 Year \_ If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. NOV 13. 1951 Maryland 217-62-9767 58 Director Jsual Residence of Decedent "natural", or items 23a or 28a-f show diral Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Anne Arundel 1 Yes 2 X No Galesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4820 Riverside Drive 20765 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian ğ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Carpenter Marine Restoration permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other amy injury or other traumatic event, tt onee. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Melvin Delbert Zang Mary Margaret Hagen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Buckler, sister 4820 Riverside Drive Galesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/30/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death and Neck Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Duri to for as a possedurino) offi attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) who completed cause of death (Item 23a) (Ripe, Print) ame and address of p

State Registrar 31. Date filed (Month, Day, Year)

SEHIGHWAY

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death William W. Allen 6:58pmM 09,2010 March County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park Washington Adventist If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/11/31 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min 1⊠M 2□ F 579-36-2171 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Washington 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20017 4900 11 Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Engineer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Allen George Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4900 11 St NE Washington DC 20017 19a. Informant's Name/Relationship (Type. Print) Denise Lockett Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 3/15/10 Laurel, Maryland 21. Signature of Funeral Service Licensee Shead Mortuary Service, P.A. 1409 Fairlakes PL Ste B Mitchellville, Md 0717 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) I ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐XYes 2☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

DC

Director

Funeral

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Completed

Be

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**Funeral** 

Director

if than "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or itel any july or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

death with the Maryland

Examiner attending physician and for use as the burial-trans Physician/Medical been signed by the a should be detached t Completed by cate has been s page 2 should certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be မ Certification:

COPD HTN

Seizures 25. Was case referred to medical examiner?

27. Manner of Death Natural 5 ☐ Pending investigation 2 Accident 3 ☐ Suicide

29a. Certifier

6 ☐ Could not be determined 4 ☐ Homicide

Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Hysician 29c. License number WD33288 29d. Date signed (Month, Day, Year) 3/11/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1150 var wum STHE washington De 20017 William J. Crillandon 31. Date filed (Month, Day, Year)
MAR 16 2010

State Registrar

Medical

To the within 2

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bernard Anderson Sr. 6:20 AM 3 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death P.G. Bradford Oaks Nursing Home Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min Months Days Hours 215-26-3576 1 XM 2 ☐ F 79 Wash, D.C. 12-24-1930 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7520 Surratts RD. U.S.A. 20735 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Tyes 2 No 1951 If Yes, Give Year or Dates: 1954 Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 ▼No Specify. Specify: 3 Widowed 4 Noivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon Anderson Wilheminia Bakerville 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Howard (Daughter) 10800 Indian Head Hwy Ft. Wash MD. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place)m . 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 3-29-2010 Cheltenham MD. Cheltenham Vet 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hunt Funeral Home + reising 908 Kennedy St. N.W. Wash, 20011 Hunt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) un tia Due to (or as a consequence of): evabrol VARULA Sequentially list conditions, if any cause in the Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 →No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **N**o 1□ Yes 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MD

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

72 hours after

I Hygiene.

marked other traumatic event,

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event

Baltimore, Maryland 21215-0036

burial-tran physician the as attending plant of the season the detached Ś signed t peen has certificate this

Physician/Medical Be After

the death certificate be executed or Attending Physician: death. To the Funeral Director: completely filled in by the after To the Hospital hours

Completed

P

Certification:

Medical

Division or Vital Records, P.O. Box 68760,

within 24

26. Place of Death (Check only one)

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Tyes

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

া 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anna 32. Registrar's Signature

5 Pending investigation

6 Could not be determined

11701 Gringston Road

31. Date filed (Month, Day, Year) State MAR 1 7 2010 Registrar

1 Yes 2 100

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March March Physician/ 1:55 am Nathan Bindeman 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 09 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗶 M 2 🗆 F 89 Director Maryland 578-18-9702 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10c. City. Town or Location filed within 72 hours after death with the Maryland Completed by Funeral Director 1 🗌 Yes 2 💢 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6901 Heatherhill Road 20817 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WWII 3 X Widowed 4 Divorced White. Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Drobis Isaac Bindeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 717 Edelblut Drive, Silver Spring, Maryland 20901 Jody Bindeman - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 💢 Removal from State King David Mem. Grdns! 03/16/2010 Falls Church, Virginia 4 Donathon 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signa are of Juneral Section en ee M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
12-24 howrs Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Examiner <u>Atherosclerotic Vascular Disease</u> Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or ohysician and the burial-transit certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 X No 1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DADERIGO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

113/2010

レイナーナメ

BINDEMAN

Kimberly Beth Zuzak, MD, 8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** MARJORIE 0845 M BARLOW MARCH 10,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY OLNEY HOSPITAL MONTGOMERY MENERAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, **Funeral** Year. Days Hours 1 M 2 X F Min 20, 225-36-2776 79 1930 Director Oct. Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1XIYes 2 □ No Director Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 4856 Brooks Street NE 20019 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Annuity Specialist Government s 1 and 2 should be filed w if Health and Mental Hygier item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chester Williams Annie Shephard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai 13123 Brooktree Lane Laurel, Maryland 20707 Ingrid Hill Butler/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln
Memorial Cemetery 2010 20c. Location - City or Town, State 20a. Method of Disposition March 17 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licent 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY ACUTE /Medical Due to (or as a consequence of): Examiner MULTILUBAR PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed and burial-tran Due to (or as a consequence of): physician law requires that the death certificate be Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for 1 Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ WITH SEPSIS 1 Yes 2 No 3 Probably 4 Unknown Completed SEIZURE DISORDER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No HISTORY OF 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760. P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director: A Hospital

completely

O. ADEWUNMI, MID LUYEMISI 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Usausurloz, MD

Registrar

(Check only

29b. Signature and title of certifier\_

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D59418

29d. Date signed (Month, Day, Year)

MONTGOMERY GENERAL HOSPITAL

MARCH 10,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 11 2010 8:02 Α Dona1d Dean Bequeaith Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick 9. Birthplace (State or Foreign Country)
Illinois If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Hours 1 ☑ M 2 ☐ F 321-24-9252 80 08 - 17 - 1929Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.
A 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, it is the contined at the traumatic event, it is the contined at 1 ☐ Yes 2 X No Director MD Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2380 Plum Point Road 20639 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 □ No
If Yes, Give
Year or Dates: 1947-67 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Navv 12 Chief Radioman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Dixon Gilman Bequeaith Gertrude ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2380 Plum Point Road, Huntingtown, MD 20639 Item 27 other t Joyce A. Bequeaith, spouse Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department o Important: If any Injury or once. MD Veterens Cemetery 03-19-2010 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocouche disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arter Covarian Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 ☑ No 1 □ Yes or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To nours after death.

neral Director; After this filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 24 hours a The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+ M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD David Tardio, 32. Registrars Signature 31. Date filed (Month, Day, Year) State barke MAR 16 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2010 16 4:38 A M Alfred Burcker George Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15020 Hicksville Road Clear Spring Washington 8. Date of Birth
(Month, Day, Year)
Oct. 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Director 220-34-0150 Maryland 1937 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington 1 ☐ Yes 2 🌠 No Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15020 Hicksville Road 21722 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic conce. Supervisor Sanitation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Raymond Francis Burcker Mary Lillian Virginia Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae E. Burcker/Wife 15020 Hicksville Rd., Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/19/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 22. Name and Address of Facility 5. Mark 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition yed Medical resulting in death) Due to (or as a consequence of): Examiner Dequantially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Month 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown moloma . Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury\_at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident
Suicide Investigation Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

5H-3

within 2 To the I

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

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32. Registrar's Signature

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month. Dav. Year)

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Funeral Director		5. Social Security No.	umber 6.		. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day AUG	g. Birthplace (State or Foreign				
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e Maryla r 28a-f s notified	Funeral Director	MD  10e. Street and Nun		GOMERY	P	AMOTO	C 10f. Zip Code			10 000	614/h-1-1-C	1 ☐ Yes 2 🗖 No		
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d 2 shoul alth and 1 27 is m er trauma		19a. Informant's Na MEG B.			TER			and Number or Rura					0842	
Page 1 an nent of He int: If iten iry or oth		20a. Method of Disp 1 Burial 2 4 Donation		Removal from S	tate ST	lace of Dispo emetery, cren AUFFE	sition (Name of natory or other plac R CREMA	TORY 3/1	1/10	FREDE				
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Physician/		shock, or hear Immediate Cause ( disease or condition	rt failure. List only Final	one cause on each	IRATO	RY FA		ng, such as cardiac c	or respiratory arre	est,		Approxim Interval B Onset and 24-4		
Medical Examiner		resulting in death)  Due to (or as a consequence of):  SEPSIS  Sequentially list conditions,											6 hrs	
ii a e	al Examiner												month	
to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but $2 \mathbb{Z} = $	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 7 g ☐ Unknown	months?	23c. If yes, outco	rth 2 ☐ Feta ınt at time of d	death 3	Ectopic pregnand Other (specify)	су			Date of delive	very Day	Year	
equires that the een signed by rould be detaction in the contraction i	þ	Part II. Other signif	icant conditions	contributing to dea	th but not resu	ulting in the u	inderly <b>ing</b> cause gi	ven in Part I.	23e. Did to	bacco use co 'es 2 No			f death?	
The law rec	Completed								24a. Was a autop perfor	med?	prior to co death?		s available f cause of	
sician: The certificate irector, pag	Be	25. Was case referred examiner?  1  Yes 2	1	Hospital:	patient 2 🗆	ED/Out-stie-	Oth	lace of Death (Check			4h 4O i4			
nding Physath. r: After this e funeral di	Certificate: To	27. Manner of Death  1 Natural 2 Accident		28a. Date of (Month,		28b. Time of injury	28c. Injur work	y at Yes 2 No	28d. Describe ho			<u>y)</u>		
Hospital or Attendi 24 hours after death Funeral Director: A eted filled in by the f		3 ☐ Suicide 4 ☐ Homicide	6 L Could no determine	28e. Place of	f Injury - At hoi i, etc. (Spec <i>ify)</i>		eet, factory, office		28f. Location (Si City or Town		nber or Rura	al Route Nui	mber,	
To the Hospita within 24 hours To the Funera completed fille	Medical	(Check 2 only one) 3	Medical Exa	miner: On the basis	of examination	and/or invest	tigation, in my opini	e, date and place, an on, death occurred at ne time, date and place	t the time, date ar	nd place, and	due to the ca	ause(s) and r	manner stated.	
To the within 2 To the comple		29b. Signature and	title of certifier	-			29c. Licens	e number	3	29d. Date sign		Day, Year)		
5 W		30. Name and addre	DT 17 (711)	7777	8600	OLD G		WN RD.,	BETHES	SDA, M	1D 2	0814		
Stat Registra	e ir	31. Date filed (Monti	h, Day, Year)	1 20 0 32. Reg	istrar's Signat	ure	Jake							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2010 Physician/ MARCH 14, ETHEL MILDRED MC LEOD BRELAND 1326 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES FORT WASHINGTON HOSPITAL FORT WASHINGTON Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday **Funeral** Hours 1 - M 2 X Days SPPIMBER 25,1919 MESSISSIPPI 428-22-7647 90 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MARYLAND BRYANS ROAD CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20616 UNITED STATES 6893 ARBOR LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 YEARS Elementary/Seconday (0-12) **EDUCATION** EDUCATIONAL SPECIALIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VIOLA MORRIS MC LEOD BILL MC LEOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6893 ARBOR LANE, BRYANS ROAD, MARYLAND SHERRA N. NELSON / DAUGHTER 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or MACEDONÍA CHURCH CEMETERY MARCH 20, 2010 BRYANS ROAD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Sure of Funeral Service Conse THÖRNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THURNIUN JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate terval/Between set and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to y as a consequence of: Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury as the burial-transi or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-tran that initiated events resulting in death) Last Due to (or consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🖪 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? has this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 🗂 No 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar з 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

29b. Signature and title of

31. Date filed (Month, Dav. Year)

MAR 17 2010

LAXMI BERWA, M.D. 7700 OLD BRANCH AVENUE, SUITE 101, CLINTON, MARYLAND 20735

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3712/2010 7:54 Ам Dallas Lee Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Community Hospital Prince Georges Cheverly If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖳 M 2 🗆 F (Month, Day, Year) 8/13/1944 Country) 65 NC Director 245-66-1844 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director Prince Georges Suitland MD 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 3705 Stonecliff Road 20746 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 X Yes 2 No If Yes, Give 62-68 Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Minister Private 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Johnie Ann Brown James E. Fenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Brown / wife 3705 Stonecliff Rd, Suitland, MD 20746 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 s Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cheltenham, MD 3/26/2010 Maryland Veterans 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bianchi 814 Upshur ST NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician Fatal Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death
Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitis 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Colon History 04 Cancer 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 잍 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending iniury ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital DR. Cheverly, MD

Registrar

pana

MAR 1 8 2010

Maha

ngashetti

10-01963 Mary J. Baker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary J. Baker		- For State Registrar	State of N	Maryland i		irtment of tificate of		ind Me	ntal Hy	_	eg. No. 2	01	0 09721
Physiciar Medical Examin	1/	Decedent's Name (First,		Baker			,		[	2. Date of Dea Month March 9,	Day	Year	3. Time of Death 1605 hrs
		4a. Facility Name (if not in	stitution, give stree	et and number)		4	b. City, Town,	or Location	n of Death	Wildron o,		nty of Dea	th
Funeral Director		Peninsula Region  5. Social Security Number  215-20-1717	6. <b>\$</b> ex	7. Age	e (In yrs. la	ast birthday)	Salisbury  If Under 1 \( \)  Months \( \)	ear If Un	nder 24Hrs.	1	rth(MM/DD/Y	YYY) 9. B Fore	irthplace (State or
	ŀ	Usual Residence of Deced	1 M ent	2 <b>X</b> F		Yrs.				06104	1926		our Maryland
ow any		10a. State 10b. Co				Town or Location							10d. Inside City Limits 1 X Yes 2 No
aryland Sa-f show	힣	Maryland W 10e. Street and Number	licomico		F	ruitlan	d 10f. Zip Cod	9		- T	10g. Citizen of	What Co	
the Missor 22	Director	417 W. Ma	in Stree	et			218	26			USA	Ą	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral	_	X Married 1			If Ye	es, specify Cu	oan, Mexica	an, Puerto F	ecify Yes or No Rican, etc.)	v	Vhite, etc.	erican Indian, Black,
urs after lural",	a	3 Widowed 4 15. Decedent's Education	Divorced If Yes or Da (Specify only hig	ates:	npieted)	16a. Decedent	Yes 2 X			ork done	Speci 16b. Kind o	-	white s/Industry
6 n 72 hou an "nai	Completed	Elementary/Secondary (	0-12) C	College (1-4 or 5	5+)	during mo	st of working	life. DO NO	T use retire	ed)			
5-003 led within Hygiene. other th	ě.	12 17. Father's Name (First, N	liddle, Last)			teach	ers ai		er's Name	(First, Middle,			ducation
21215-0036 Juld be filed within 7 Immarked other than the event, the Medica	Be	Leroy Guth								rumond			
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental 11 it filten 21 marked other traumatic event,	2	19a. Informant's Name/Rel George Bake				4	,			ural Route Nu uitland			
ore, MC ss 1 and 2 s of Health at If item 27	-	20a. Method of Disposition				Place of Disposi crematory or oth	tion (Name of	cemetery,	-/ FE	Date	20c. Locati	on - City o	or Town, State
imol Pages ment of tant; I		4 Donation 5 Ott	ner Specify:	emoval from Sta	ale	lisbury	Crema	_	3 1	2 2010			y, MD
Baltimore, ME permit. Pages I and 2 s Department of Health at Important; If item 27 injury or other traum		21. Signature of Funeral S	ervice Licensee	1		<sup>22</sup> <b>P</b>	orroda Ol Sno	yss <b>r</b> tan √ Hil	eral 1 1 Rd	Home Pr , Salis	ofessi bury,	onal MD 2	Association 1804
Physician /Medical	1	3a, Part I. Enter the disea failure. List only one	cause on each line	e.									Approximate Interval Between Onset and Death
aminer	1	Immediate Cause (Final di or condition resulting in de		pertens o (or as a conse		atheros	clerot	ic car	rdiova	asculai	disea	ise	Death
	اير	Sequentially list conditions if any, leading to immediat		o (or as a conse	equence of	f)·			<del></del>	<u></u>			
	Examine	cause. Enter Underlying ( (Disease or injury that initi	Cause c.	o (or as a conse									
cuted nd ransit	Ë	events resulting in death)	Last Due to	o (or as a conse	equence of	1).							
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 3b. Was decedent pregna past 12 months?		c. If yes, outcor		2 Fet	al death	3 Ecto	pic pregnar	псу	23d. Dat Mont	e of delive	Day Year
Box 687 e death certificathe attending ped for use as the	ysici	1 Yes 2 No 9	Unknown 9	Pregnant at Unknown	time of de	ath 5 Oth	er (Specify)						
that the d	by Phy	Part II. Other significant o	onditions contr	ributing to death	n but not re	esulting in the u	nderlying cau	se given in	Part I.		obacco use c	-	o the cause of death?
ords, F	sted 1									24a. Was		4b. Were a	autopsy findings available
ecor	Completed	-								auto perfe	psy ormed? 2 No	prior to death?	
ital Reccitian: The large certificate ha	ပ္က မ်ို	25. Was case referred to n							th (Check o				- [
of Vit	와	1 ✓ Yes 2 N 27, Manner of Death		al: 1 Inpatie 8a. Date of Inju		ER/Outpatient 28b. Time of Ir		Other <sub>4</sub>		Home 5 28d. Describe	Residence		er:
on of \ ending Phy ath. or: After ti	ţio	1 X Natural 5	Pending	(Month, Day,Y	ear)		1		_		,,		
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	Certification:	2 Accident 3 Suicide 6	Could not be		jury - At h	ome, farm, stree	t, factory, offic	e building,	etc.	28f. Location or Town,		umber or F	Rural Route Number, City
lospita 4 hours uneral		4 Homicide  29a. Certifier (Check only 1 Certify	ring Physician: T	(Specify)  o the best of m	y knowled	ge, death occur	ed at the time	, date and	place, and	due to the cau	se(s) and mai	nner as st	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medica	al Examiner:On to and				on, in my opir	ion, death	occurred at		and place, a	nd due to	the cause(s)
	Σĺ	29b. Signature and title of	certifier	/	M	,		ense numb	er		29d. Date:		fonth, Day, Year)
		30. Name and address of p	person who com	cause of d									
	1	Russell Alexande		stant Medic			Penn Stre	et, Baltir	more, ME	21201			1
Sta Registr	te ar	31. Date filed (Month, Day,	T6 2010	32. Fegistra	r's Signatu	d. pa	Har						

DHMH 17 Rev 1/2001 OCME 2006 UUIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Marie Wailes Bailey Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death. REGIONAL 54/136414 HICOMICO Nedicol If Under 1 Year I If Under 24 Hrs. 8, Date of Birth Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Min B 12011917 **Director** 214-32-0673 92 Maryland Usual Residence of Decedent show 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ed other than "natural", or items 23a or 28a-fs event, the Medical Examiner must be notified 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1109 S. Schumaker Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 → No Specify. Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Hastings Brothers Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alma Parker Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Palmer daughter 32 S. Horseshoe Drive,Milford, DE 19963 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 3 | 15 | 2010 Salisbury, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bollsway Funeral Home P.A. ,Salisbury,Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner (DEDNART DISEASE HETER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🔲 No Yes 2 1 🗌 Yes completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury hours after death. 1 Tyes 2 🗌 Na Accident Investigation Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier MD D58689 Ours A M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar TomASZ

Date filed (Mont)

roll St. Salisbury Md.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Roberta I. Brown March 15, 2010 5:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1785 Stinnett Road Huntingtown Calvert 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 KF Months Hours **Director** 214-32-9395 February 19, 1924 MD Usual Residence of Decedent ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If fiem 27 is marked other than "natural", or Items 23a or 28a-5 shown 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Calvert Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1785 Stinnett Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify \$ 3 ₩ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Randy Keemer Edith Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Bowie Lane, Huntingtown, MD 20639 Cora Drumgo - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) St. Edmonds UM Church Cemetery | March 20, 2010 | Chesapeake Beach, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophagea **Physician** /Medical Due to (or a conse lence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Exami and -tran Due to (or as a consequence of) burial-Physician/Medical the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 ∐Yes 2 XXNo 1 □Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home State Residence 6 Nother (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician: The law requires that the death certificate be executed Box 68760. physician attending pl P.O. signed I Records, has certificate Division of Vital or Attending death.

Maryland 21215-0036

Baltimore,

n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu Hospital completely within 2 dew 10

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

1 💢 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARMI PATEL 110 HUSPIFAL ROAD,

31. Date filed (Month, Day,

4 Homicide

(Check only

29a. Certifier

one)

32. Registra s Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of H			giene	0	09727			
	Tr.		1. Decedent's Name (First, Middle, Las	ų ,				2. Date of Dea						
	Physici		Betty ANN K	LOUNDS BC	NANT			Month 3	9 20	4:15 a <sup>M</sup>				
7	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	0	4b. City, Town, or	Location of Deat	h	4c. County of	f Death				
			801 Price Road			Salisbu	ırv		Wicomico					
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h		ce (State or Foreign			
	Director		219-36-6907	□M 2DXF 71	Yrs.	World Days	Trours with	12-15	-1939	MD				
	DG 💌		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	aglion				100	d. Inside City Limits			
	anyta eho	'n								100	TX□Yes 2□No			
	788-f	ecte	MD Wicomic	o   S	alisbu				10g. Citizen of W					
	with	늅	801 Price Road			10f. Zip Code 21801		1	J.S.A.	nat Country	y:			
	eeth	erai	11. Marital Status	12. Was Decedent Ever in	1119 13	Was Decedent of H	ispanic Origin? (9			- Americar	n Indian			
21215-0036	be filed within 72 hours after deeth with the Maryland nat Hygiene.  ed other than "naturel", or Iteme 23e or 28e-f show event, in Madical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 XNo	Specify:	to Rican, etc.)	Black	14. Race - American Indian, Black, White, etc. Specify:Black				
ò	2 hou	Completed	15. Decedeni's Ed	ucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	iness/Indu	istry			
215	n c	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo l)	rking	Evergl	ades	Memorial			
212	d with	Eo	12	College (1-401 5+)	Hous	ekeeper			Hospit	al				
	be filed tal Hygi d other event, ii	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame	i)				
<u>a</u>	Alanta Alanta rked tic e	70	James Rounds				Hazel Ayres							
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773	1 and 2 Health em 27 I		Haden Bryant/H	lusband	801	Price Ro	oad, Sa	lisbury	, MD 2	1801				
ore	of He		20a. Melhod of Disposition  12 Burial 2 Cremation 3		<ul> <li>Place of Dispo cemetery, cre</li> </ul>	osition (Name of matory or other place	e)	Date	20c. Location - 0	City or Town	n, State			
Ĕ	Pages ment of ent: if it ury or o		4 Donation 5 Other (Specify	) M	t. Wes	ley Cem	3/1	3/2010	Snow H	ill,	MD			
Baltimore,	permit. Pages 1 and 3 Depertment of Health Importent: if Item 27 eny injury or other tr. \$00.00.		21. Signalure of Funeral Service Licen	Rnul	s of Facility 91 Home Sa	7 W. Is	sabella	St. 1801						
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de						A	Approximate nterval Between			
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Division	death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be		theme form at		Yes 2 □No	OOF Leasting (	Steppt and Number	e of Pural	Douts Alienbar			
≥	etter Direction by	it is	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	reet, factory, office		City or To	Street and Numbe vn, State)	7 OF HUTAI I	Abute (vumber,			
_	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely tilled in by the tune		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge desi	th occurred at the time	ne date and also	e and due to the	cause/e) and ma	ner as at-	ited			
	To the Hospita within 24 hours To the Funerel completely tilled	Medical		niner: On the basis of exam and manner stated.	ination and/or ir	ivestigation, in my o	pinion, death occ	curred at the time,	date and place, a	nd due to t	ted. the cause(s)			
	omple	Ze S	29b. Signature and title of gertifier			29c. Licens	e number		29d. Date signed	(Month, D.	lay, Year)			
	h		* k (\ / / / )			baa	1.1-1-	7 1/	77.1	2)	ld z usay			
	2.		30. Name and address of person who	ompleted cause of death (	Item 23a) /Tuno	Print)	01 0	14	4/11/	/				
	MM		JAJ Carland	171/	L 1.	nich wie	m. (2)	1-1	. da	in	א אוראוני			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 5:37 Hedwig Elizabeth Courter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 9. Birthplace (State or Foreign Country)
New Jersey 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 💢 F Months Days Hours Director 152-10-5993 93 Dec. 916 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18623 Preston Road 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Mamied ò Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charles Ohlson Innis Ostergren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Courter/Son 14554 Wingerton Rd., Waynesboro, PA 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 3/18/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Rest Haven Funeral Chapel ا د Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of Immediate Cause (Final nset and Death Physician/ rusa disease or condition resulting in death) enc Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lo Examir and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician at for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months? Month Day Vear Pregnant at time of death signed by the a 9 Unknown P.O. ng to death but not resulting in the underlying dause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should I . Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performe death? this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No ျှ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

29b. Signature

SHAHAB 31. Date filed (Month, Day, Year)

and title of certifier

30. Name and address of person who completed dause of

ause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Tman 30 PM 110 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death ROCKGlen Rehab Balt Nursing imore If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 X M 2 - F 91 220-03-5856 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore ND 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 1923 21207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) Board Of Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Baltimore 21207 argaret 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ocomoke, 21. Signature of Funeral Service Licensee ennie 426 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) onon estille Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the and be detached for To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy performed? Yes 2 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 Tes 2 X No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 🔀 Natural work? 5 Pending injury 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Eccutiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Lacon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alhmar MD 2/2/7 اے Registr State

DHMH 17 Rev 7/2009

Registrar

P.O.

		Please Type or Pri State of M  1 - State Registrar	laryland / Depa	<b>delible Ink. Ens</b> artment of Health <i>rtificate of Death</i>	and Mental Hy	3	1 00730						
Physici /Medic Examin	cal	Decedent's Name (First, Middle, Last)     Willard Robemid Christens     4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	2. Date of De Month Meucl	Day Year	3. Time of Death 1:30 AM						
Funeral Director		Shady Grove Adventist Hosp  5. Social Security Number  475–12–5395  6. Sex  1 ☑ M 2□ F	le er 24 Hrs. 8. Date of Bir Min. (Month, De April 2	Montgor th ay, Year) 9. Bir									
th the Maryland or 28a-f show	Director	Usual Residence of Decedent	10c. City, Town or Lo	Potomac 10f. Zip Code		10g. Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 🛣 No puntry?						
ours after death w ral", or items 23a	by Funeral Director	14520 Dufief Mill Road  11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces 1 ☑ Yes 2 □ If Yes, Give Year or Dates:	No WW II	20878 Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 □ Yes 2 ₩ No Specify		United S1  14. Race - Am Black, Whit  Specify:	erican Indian,						
2 should be filed within 72 hours after death with the Maryland nard Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaminer must be rodified at	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 4)  17. Father's Name (First, Middle, Last)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)  Self Employe  18. Moti		16b. Kind of Business  Electronic  Maiden Surname)	,						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	To E	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lillian R. Christensen / Spouse 14520 Dufief Mill Road, N. Potomac, MD											
		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service ☐ Pensee	Metropoli Crema	natory or other place) Ltan atory  Name and Address of Faci	2010	20c. Location - City or Alexandria	, Virginia						
be executed light	Examiner	DeVol Funeral Home, 10 East Deer Park Drive,  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between Conset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leauling to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth	2 Fetal death 3	□ Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year						
law requires that as been signed b 2 should be deta	Completed by Ph	Part II. Other significant conditions contributing to death  Ospuration preumonia,	but not resulting in the u	nderlying cause given in Part	23e. Did to	an 24b. Were a	o the cause of death?  robably 4  Unknown  utopsy findings available completion of cause of						
Physician: The law this certificate has b al director, page 2 s	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Input  27. Manner of Death 28a, Date of Ini	ient 2 ☐ ER/Outpatier	nt 3 DOA Other: 4 D	perfo 1 □ Yes ce of Death (Check only conducting Home 5 □ Residue)	ormed? death? 2 (20) death? 1 (1) Yes	s 2 □ No						
tal or Attending s after death. al Director: After ed in by the funer	Certification:	1 Natural 5 Pending (Month, Ø 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of In		Work? M 1 ☐ Yes 2 ☐	□No	how injury occurred  Street and Number or R wn, State)	ural Route Number,						
To the Hospi within 24 hour To the Funer completely fill	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s  29b. Signature and title of certifier	of examination and/or in tated.	vestigation, in my opinion, de	eath occurred at the time,	date and place, and du	e to the cause(s)						
10+1		30. Name and address of person who completed cause of ALAW 5-CHAPMES 15225	death (Item 23a) (Type,	29c. License number 2943 Print) BUE RO RO	BEKUILE !	Monce 1	4,20,0						
Sta Registra		31. Date filed (Month, Day, Year) 32. Regist MAR 16 2010	rar's Signature		, , - , and	2003							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09731 State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2<u>010</u> Physician/ March 2115 Gertrude M. Chase 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 □ M 2 🛛 F Months Days Hours Min. Director 123-28-8744 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maruland Montgomery Silver Spring 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with 701 Jackson Road 20904 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Statue 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced Completed White er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Author 12 Psuchologu and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Kenneth Chase Maru Laird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other to once. <u> Kari Ainsworth - Daughter</u> 32499 Mariners Way, Millsboro, Delaware 19966 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1; cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 03/16/2010 Brentwood. Maryland 22. Name and Address of Facility. Simple tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland e of Funeral Service Licer 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate enval Between Onset and Death

Week Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner End-Stage COPD Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events Renal Failure Week and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Cardiac Arrest in ED. 2/23 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Multiple Personality Disorder Were autopsy findings available prior to completion of cause of autopsy death? certificate Recurrent UTI 1 Yes 2 No 1 ☐ Yes 2 🗓 No ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending 2 🖵 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the second file completed file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the 29b. Signature and title of certifier 10 Suparich, RSM, ND 03/11/2010 D 0065 485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, RSM. MD. 1500 Forest Glen Road, Silver Spring, Maryland 20910 Registrar's Signatu State acks Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAXINE MAE STEELE CALLENDER March 2010 9:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Derwood 5809 Wild Flower Court Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 515-32-3980 1 🗆 M 2 🛛 F Months Days Hours Min March 29 Director 1936 Kansas Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Derwood 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5809 Wild Flower Court 20855 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Flowers Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elba Steele Hilda Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Russell Callender (Son) 5809 Wild Flower Court Derwood, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of March 20, 20c. Location - City or Town, State 1 

Removal from State
4 □ Donation 5 □ Other (Specify) Forest Park
Westheimer Cem. West Houston, Texas 2010 Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Interstitial Lung Disease disease or condition Medical resulting in death) Due to (or as a consequence of) . Examiner 2 Years Polymyositis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 24 hours after death. Funeral Director: A: 1 Tes 2 🖵 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D35965 March 15, 2010 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 602 Center Street #209 Dr. David B. Harding M.D. Mt Airy, MD 21771 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

# altimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	o the Funeral Director: After this certificate has been signed by the attending physician and

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2 shoh and hand rism		19a. Informant's Name/Relationship (	Type. Print)		19b. Maili	ng Address (Stre	et and Number or Ru	ral Route Number	r, Cify or Town	, State, Zip	Code)				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redified at once.		4 Donation 5 Other (Specify) Greenlawn Mem. Park 3/20/10 Williamsport  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home													
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Please Type or Print in Black Indelible Ink I Engure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chastain Month atnua 7:00  $\mathbf{p}^{\mathsf{M}}$ 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 909 May Lane Queen Anne's Stevensville Social Security N286 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months October 14,1965 Washington,DC 218-90-<del>168</del>5 **Director** 44 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Queen Anne's Stevensville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 909 May Lane United States 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 Divorced 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Daycare Provider Childcare Be 17. Father's Name (First, Middle, Last) h and Mental F 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill I Health and Mental Item 27 is marked ည Milton Carter Armes Barbara Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Michael Chastain/Husband 909 May Lane, Stevensville, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of **Chesapeako**ry **Cremate on** 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or March 12 1 Burial 2 Cremation 3 Removal from State Stevensville, MD 4 Donation 5 ther (Specify) Center 2010 21. Signature of Funer Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea allure. List only one use on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death be detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø nknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate 1 ☐ Yes 2 No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: 25. Was case referred to medical of Vital To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0064376 29d. Date signed (Month, Day, Year)
3/11/2010

Jay Char Qw Bestzek Rd Sule 300 Anneply MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wilhelmina Physician/ Elizabeth Crable Montech 10:09 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George Hospital Center Prince George's Cheverly 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🔽 F Months Days 118 14 931 87 Director North Carolina Usual Residence of Decedent shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Exminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Glendale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10600 Crimson Tree Court 20769 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 3 1 Never Married 2 Married Baltimore, Maryland 21215-00% 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 □ Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Page 1 and 2 should be filed within imment of Health and Mental Hygiene. Fant: If item 27 is marked other than jury or other traumatic event, the <u>M</u> Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ralph Waldo Cantrell Keith Wilhelmina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ryvette Smith (Daughter) 10113 Legacy Court, Clinton, MD Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of 3/21/2010 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington National Cemetery Suitland, Maryland n 5 Other (Specify) Signa 22. Name and Address of FacilityLee Fuenral Home, Inc 6633 01d ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Maaryland shock Immediate Cause (Final disease or condition Physician/ CARDIAC Onset and Death Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has appleted filled in by the funeral director, page 2. performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accider
3 Suicide Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medica 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Gi Swapma D0069341 2010

State Registrar HOSPITAL DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GADDIPATI

32. Registrar's Signature

SWAPNA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 17 per fh e902 4-21-10 vt 20b State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cadwell Helen Margaret Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) MA Funeral 8. Date of Birth 1 🗆 M 2 🖵 F Months Days Hours Min. Month, Day Jul 25 Year 924 024-20-5830 Director 85 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 XNo MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 14506 Uhl Highway 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ō à 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X No Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 ☐ Widowed 4 ☐ Divorced white of Health and Mental Hygiene.
Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Labeler International Paper Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hv. Important: If Item 27 is marrany injury or other. 17. Father's Name (*First, Middle, Last)* **Cadwell** 18. Mother's Name (First, Middle, Maiden Surname) 2 Karl H. Caldwell Lillian Perkins Cadwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Nancy Howard Niece <u>14506 Uhl Highway</u> Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 Donation 5 Other (Specify) 4-24-10 North Blandford Cemetery North Blandford, MA Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Dug Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ice of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signard by the attending helician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Day Year 1 ☐ Yes ≥ 9 ☐ Unknown Unknown ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after deam.
al Director: After the in by the funer. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work Accident Investigation 1 Yes 2 No □ Accident
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifie Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calkins 500 Memorial Ave Ste 105 Cumberland MD 21502 Beverly 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 7/2009

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ROAM Grace Clark 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 714 Sylvan Avenue Allegany Cumberland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Jan 1, 6. Sex **Funeral** Months Days 1 □ M 2 □ **F** 1923 215-20-5891 ΜD Director 87 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it as Invalidate Las international tensorial at any injury or other traumatic event, it as Invalidate Las international and once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Allegany Cumberland 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Svlvan Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No If Yes, Give Year or Dates: Specify. ģ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph E. Clark Idella Shinholtz Clark ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Clark 714 Sylvan Avenue MD 21502 sister Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 3/27/2010 Scarpelli Funeral Home, P.A. Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee an 108 Virginia Avenue: Cumberland, MD 21502 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner APPROX 2 YRS CHF Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exam attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an certificate has triector, page 2 s autopsy performed? 1 □ Yes 2 DNo 25. Was case referred to medical examiner?
11 Yes 2 □ No Be 26. Place of Death (Check only one after death.

I Director: After this ce d in by the funeral direc Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registar's Signature

alale MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Louise Deryoung рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 1 F Days Hours Min. 242-26-9864 Director 86 28 192/ Jorth Carolina 6 4 1 Usual Residence of Deceden filed within 72 hours after death with the Maryland al Hygiene.

1 other than "natural", or items 23a or 28a-f sho 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 1235 Potomac Valley Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Caretaker Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked out jury or other traumatic even Unobtainable Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Kay/ Grandson 315 West South Ave, Tampa Florida 33603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State FT. Lincoln Crematory 03/19/2010Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atte in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2  $\stackrel{\times}{\square}$  No 3  $\square$  Probably 4  $\square$  Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 ANo certificate 1 ☐ Yes 2 🏝 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner?

1 Yes 2 No Hospital Other: 은 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062435 3/5/2010

State Registrar 31. Date filed (Month, Day, Year)

MAR 16 2010

DHMH 17 Rev 7/2009

Sayed Eisayyad 10110 Molecular Dr. Rockville, MD 20850

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month 12 Betty L. Davis 6:45 A Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 804 Gail Avenue Rockville Montgomery 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 5, 1 9. Birthplace (State or Foreign **Funeral** Days Min. Months 1 □ M 2 🏋 F Hours Maryland 212-74-3805 79 Director Yrs. 930 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montgomery 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 20851 804 Gail Avenue Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Poole Ernest Franklin Helbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Earley Davis (Husband) Rockville, Maryland 20851 804 Gail Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State March Parklawn Mem. Pk. Rockville, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 Years shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph<sub>\_</sub>sician/ disease or condition resulting in death) Ovarian Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine ff any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Divinto for sera consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo 3 Ectopic pregnancy Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes, Hyperthyroidism, Hypertension 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

20

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **MAR 16 2010** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Dr. Arthur Schoengold M.D.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

18188 Prince Philip Dr. #T10 Olney, MD 20832

29d. Date signed (Month, Day, Year)

March 12, 2010

29c. License number

D18726

Please Type or Print in Black Indelible lok Ensure All Copies Are Legible. Amend 20b per FH G902 4712/10 dk State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ZU 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death, Day Month Physician DUKES 13 MASON 2016 MARIE ILDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTERTOUN KENT CHESTER KIVER MANOR 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2XF Months USA. 6849 14 Director MARCH 26, 1919 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at MD 1 X Yes 2 □ No KENT WORTON Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? WORTON LYNCH 21678 U.S.A 25365 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PACKACING HEMICAL Department of Health and Mental Hygi Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FOGWELL MASON ARULINE 2 ARTHUR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/676 19a. Informant's Name/Relationship (Type. Print) STEPHENSON 2634 JN DA WILMINGTON Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State WORTEN, MD 21678 WORTON UNION CEMETRAY 3/18/10 22. Name and Address of Facility MARVIN & WILLIAMS TE FUNCE DIRECTOR 21. Signature of Funeral Service Licensee MUGELT Will 130 SPEEZ ROAD CHESTERTOWN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wood /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 27. Manne of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e and title of certifier 29c. Nicense number 006030 / 29d. Date signed (Month, Day, Year) 29b. Signar 6 30. Name and address offerson who completed cause of death (Item 23a) (Type Print) 5725 CHESTELTOWN, MJ

Registrar

State

T

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2010 SHEILA DYSON 20:22 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🛣 F Months 63 215-46-1886 Director 1946 Washington, DC Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertalt Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Completed by Funeral Director MD Montgomery Silver Spring 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 8600 16th Street 20910 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milton Dyson Myrtle Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6808 Creekwood Court, Clarksville, Md 21029 Lovette Wran - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/23/2010 | Riverdale, Maryland Riverdale Park 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 21. Signature of une at Source icensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CONGES To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical RENAL Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerform death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes Other: Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ands MD 52855 32. Regist filed (Month, Day, Year) State MAR 1 8 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2000 Michael Ann Doyle 03:15A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death atthe Wilcomico Coastal Hospice Social Security Number 9. Birthplace (State or Foreign Year If Under 8. Date of Birth . Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Hours 575-60-6782 62 Months Min (Month, Day, Year) 08 | 27 | 1947 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Quantico 1 🗌 Yes 2 🏻 No Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6313 Cherry Walk Road 21856 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Be Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 K No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) human resources specialist electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barbara Frederickson William Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6313 Cherry Walk Rd., Quantico, MD 21856 Scott Duncan/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3 | 15 | 10 Salisbury, MD 4 Donation 5 Other (Specify) Sid nera Service Lic 22HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1. Enter the disease, or complications that caused the Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ CANCRA disease or condition resulting in death) Medical Due to (o) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes No
9 ☐ Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death. Director: After this certificate has autopsy performed 1  $\square$  Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier PMOI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAR 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ANNIE LOUISE EADDY narch 10,2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🕱 F 68 8/18/1941 250-76-8605 Kingstree, SC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No Maryland | Prince George's Landover 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7607 Burnside Road 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🏝 No Specify Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabella Pressley Joseph Washington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josie Pollard / Daughter 7604 Martha Street Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/19/2010 Clinton, Maryland Resurrection 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, maryland 20747 23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final gastro intestina 1 Bleedi disease or condition resulting in death) Due to (or as a consequence of): wheeloms Eon Hepatitis B Virus Due to (or as a consequence of): tematuria IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident

**Physician** /Medical Examiner

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page 2

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certificate |

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After 1

after death the

within 24 hours a

Physiclan:

or Attending

attending physician

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be ္

Examiner

Physician/Medical

þ

Completed

Be

Medical Certification: To

3 ☐ Suicide

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Evar it we must be notified at

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

investigation

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

18PPZ00Q

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3/10/10

4 Homicide 29a, Certifie (Check only

And ella, mo

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12200 AUNAPOLIS ROAD SUITE 229 GLENK DALE Abdello, ins Mukemil

State Registrar

31. Date filed (Month, Day, Year) MAR 1 7 2010

29b. Signature and title of certifier

mukemil

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2<u>010</u> Physician/ 9:25 A M 08. MARCH  $_{
m LEE}$ ELLERBE, Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER 9. Birthplace (State or Foreign Country) Hamlet, NC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** (Month, Day, 17/193 1 **X** M 2 □ F 76 Director 579-48-5477 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. Director X☐ Yes 2☐ No Maryland Prince George's District Heights 10g. Citizen of What Country? 10e. Street and Number Funeral 20747 United States 7420 Marlboro Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced Completed 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event. Hts. MA-College (1-4 or 5+) Elementary/Seconday (0-12) Private Cook Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Maggie Blue Ora Dorothy Ellerbe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7101 Bensley Commomn Lane #129 Richmond, VA 23237 Ora Dorothy Ellerbe / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/17/2010 Triangle, VA <u>Quantico National</u> 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the dise e.e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final with meters tuses ancinoma Physician/ disease or condition resulting in death) , Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) 4 Pregnant at time of death
9 Unknown ed by the a detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, page 2 should be de Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Other: 2 🕨 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number MARCH 9, 2010 D0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) assence SE Such 310 Washington DC RICHARD PALMER 1328 Southern 32. Regist ar's Signature 31. Date filed (Month, Day, Year) State MAR 1 A 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EDWARDS Day Month 20 Year **Physician** 6:50 AM LENONE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD SECOURS BALSIMONE BON HOSPITHU 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 6. Sex 8. Date of Birth **Funeral** Months Davs Hours 1 ☐ M 2 🂢 F 577-68-2882 Washington, DC Director 11/11/1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ortant; If Item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examination and the inviting at No Yes 2□No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 713 - 21st Street, N.E. 20002 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 □Yes 2√ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: Black 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public School Cook Sth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental int: If Item 27 is marked o un-av l Zelma Grisson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kinberly Walker - Daughter 7206 Palmetto Sunrise Ct.; Brandywine, Maryland 20613 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 3/17/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signa ure I f Funeral Service Licensee 4594 Beech Road; Temple Hills, Maryland 20748 Approximate Interval Between Onset and Death Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. the 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 □ Yes 2 ★No. 2 KNo Division of Vital 1 □ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month. Day. Year)

ommanweather

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 06 8:20 am Edna Friedman 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maplewood Park Place Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Hours March 19 Country) New York Director 213-40-5874 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maruland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9707 Old Georgetown Road, 20814 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 🗓 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Edelman Rose Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reid Chambers - Son 315 Little Falls Street, Falls Church, VA 22046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 🔲 Burial 2 🛛 Cremation 3 🗌 Removal from State Lincoln Crematory 03/15/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) ature of Fune al Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Sign MOOTO 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enjer t ne dis<sup>c</sup>ase, or complications that ca*u*sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Muelodusplastic Syndrome Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 1 Yes 2 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗓 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 1 🗆 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D55258 March 08, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6430 Rockledge Drive, Suite 470, Bethesda, Maryland 20817

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) AR 16 2010

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 March 137 10:40A M James E. Frederick, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4308 Monroe Street P.G. Colmar Manor Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours **XX**M 2□ F Min. 62 Yrs 579-58-6496 Director 6-17-47 Wash. DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the thickest Evan instrust by notified at X Yes 2 No MD. P.G. Colmar Manor Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or U.S.A. 20722 4308 Monroe Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other the 1 1 2 2 No 1 1 2 Yes 2 No If Yes, Givel 0 18 1967 Year or Date 13 1970 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ Klo Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Bricklayer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bennie Martin James E. Frederick, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20010 3540 Hertford Pl. NW Bennie Session/Mother D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Riverdale Park Riverdale, Md. 3/20/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hackett's Funeral Chapel, Inc. Mackest ella w 814- Upshur Street, N.W. DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CARDIOMYOPATHY Immediate Cause (Final Physician disease or condition resulting in death) /Medical ENSIVE HEART DISTANCE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-trans physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year 5 Other (specify) detached 9 Unknown n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 ☐ Unknown 1 Tes 2 **2** Dio Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' After this certificate 1 ☐Yes 2X No 1 🗆 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 1 TYes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27 Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ours after death.

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filled in by the fu

death with the Maryland

Medical

To the Hospital within 24 hours a To the Funeral C

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

March 15, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A. Gooray, M.D. 1450 Mercentile Lane S-217 Largo, Md. 20774

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year) 16 2010

29a. Certifier

29b. Signat



DHMH 17 Rev 7/2009

Registrar

10-01863 Carolyn Gorsuch Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 5, 2010 Medical Examiner CAROLYN HOPE FERGUSON 1629 hrs (20esuch 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Kent Chestertown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Director MD 216 56 0701 1 M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD KENT 1 Yes 2 No HESTERTOW s 23a or 28a-f show e notified at once, or 28a-f show hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BAYSHORE 22924 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes WHITE 1 Yes 2 No specify: Divorced If Yes, Give Year 3 16a. Decedent's Usual Occupation (Give kind of work cone 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 of Health and Mental Hygiene. Baltimore, MD 21215-0036 3 TTORNEY 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname PATRICIA JAVID HUNDLEY 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/6 200 If item 27 is STREET AVID REGUEN HESTERTOWN: 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 crematory or other place) Burial 2 Cremation 3 Removal from State AKE CREMATORY Donation 5 Other Specify M00625 21. Signature of Funeral Service Lice CHESTERTEUN GREEN HEREN WAY Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Mixed drug (Doxylamine, oxycodone, carisoprodol) Approximate Interval **Physician** ween Onset and /Medical Death intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED 27,28af,perm,E g901 3/31/10 TT be Box 68760 The law requires that the death certificate 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, P.O. <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed\* death? 1 ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this ပ 1 🗸 Yes 2 No 28a Date of Injury (Month, Day, Year) After 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural Pending 1 Yes 2 X No Director: Fd 3:30 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 22924 Bayshore Rd hestertown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be residence determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 O.C.M.E. March 7, 2010 Oa 30 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Marth egistrar's Signatu State 8 2010 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 10, **Physician** 2010 10 · 15P <sup>™</sup> **BETTY** С. GARVILLA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5261 MORRIS ROAD PITTSVILLE WICOMICO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2∏F 040-36-4216 Director 1942 PAUsual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a, State 10b. County "neturel", or items 23e or 28e-f show of call Examiner must be notified at 1 ☐ Yes 2 No MD WICOMICO Completed by Funeral Director PITTSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 5261 MORRIS ROAD 21850 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 te marked other then "neturel", or Iter 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 T Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES BERKHEIMER BETTY BARDALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 le any injury or other tret once. 5261 MORRIS ROAD, PITTSVILLE, MD 21850 JOSEPH B. GARVILLA - HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) \_3-15-2010 MILLSBORO, DE FIRST STATE CREMATION 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES 609 E. MARKET ST., GEORGETOWN, DE 19947 ni Short Llorge 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial. **Physician** /Medical ardiovascular Disease Examiner pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ras a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physiclan/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗆 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No eted 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Compl 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 22 No Other: 4 Nursing Home 5 A Residence 6 ☐ Other (Specify) 2 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours and To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Physician

State

1820 Sweet Bay Drive, Suite 101 Salisbury, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

JONATHAN C. Patrowicz, D.O.

31. Date filed (Month, Day, Year)

10-02241 Matthew G. Golden

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 09751

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isicat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office bu		or Town State)	and Number or Rural Route Num	ber, City				
Division or spiral or Attending rours after death.  neral Director: After filled in by the function: Certification:	3 Suicide 6 Could not be determined	(Specify) Single Family			007 Rawlings La	ine, Rawlings , MD					
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours leaded and the confidence has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the page 2 should be detached for use as the complete of the page 2 should be detached for use as the complete of the page 2 should be detached for use as the complete of the page 2 should be detached for use as the page 3 should be detached for the page 3 should be a should be		To the best of my knowledge, do the basis of examination and/or	eath occurred at the time, date r investigation, in my opinion,	e and place, and du death occurred at tl	ue to the cause(s) a he time, date and pl	nd manner as stated. lace, and due to the cause(s)					
To T com	29b. Signature and title of certifier	d manner stated.	29c. License			Date signed (Month, Day, Year)					
	O.C.M.E. March 20, 2010										
	3. Name and address of person who empleted cause of death (Item 23a)										
2	Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
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45	Physic /Medi		JUNE	ELIZABETH	[	SCHUMA	NN	H	OLT	]	March 1			eai	10:5	8 A <sup>M</sup>
200	Exami		4a. Facility Name (If not institution	on, give street and nun				Town, or	Location o	of Death		40	. County of	Death		
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	Funeral		5. Social Security Number	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs.		If Under Months	r 1 Year Days	If Under a	Min. 8	3. Date of Bir (Month, Da	rth a <i>y, Year</i>	) 9	9. Birthp Coun	lace (State try)	e or Foreign
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma  3 ☑ Widowed 4 □ Divorce	rried Armed For 1 ☐ Yes If Yes Giv	ces? 2 No e	!? If Yes, specify Cuban, Mexican, Puèrfo Rican, etc.)  ] No 1 □ Yes 2 ☒ No Specify:								White,	etc.	
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30,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nighry that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):													
P.O. Box 68760,	the death certifi y the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ O 9 ☐ Unknown		rth 2□Feta ant at time of d	aldeath 3□	]Ectopic p ] Other <i>(sp</i>						23d. Date of Month		ry Day	Year
	aw requires that s been signed to should be dete		Part II. Other significant condit	•		ulting in the u	nderlying o	ause give	n in Part I.		23e. Did t	tobacco	use contrib	ute to th	e cause o	f death?
rd	equire en sie	ed	Parkins	00'5 UI.	souse						1 🗆	Yes 2	<b>20</b> N∘ 3	☐ Prob	ably 4 [	]Unknown
Records,	The law rete has be age 2 sho	Completed by									24a. Was auto perfo	psy ormed?	prie de:	or to cor ath?	npletion of	s available cause of
Vital	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical	al le					26 Place	of Death /	1□ Yes Check only o	2 <b>X</b> N	0   1	Yes	2   NO	
>	Physiclan: this certific ral director,	To B	examiner? 1 ☐ Yes 2 <b>20</b> No	Hospital:	patient 2 🗆	ER/Outpatien	t 3□ D0	Othe	r:				6 DOther	(Specifi	d	
ō	g Phys er this eral dir	اڃا	27. Manner of Death	28a, Date of	f Injury	y 28b. Time of 28c. Injury at				4 Nursing Home 5 Hesidence					′)	
Ю	nding F th. : After e funera	텵	1 Natural 5 Pendi 2 Accident invest	ng ( <i>Monti</i> igation	h, Day Year)	Injury	М		? ′es 2∐!	No						
Division or	al or Attend safter death. I Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could	nined   266. Place	of injury - At ho ig, etc. <i>(Specif</i> )	ome, farm, str	eet, factor	y, office		28	f. Location ( City or To			or Rura	l Route Nu	ımber,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifyi 2 Medica	ng Physician: To the I Examiner: On the ba and mann	sis of examina er stated.	ation and/or in	vestigation	n, in my op	oinion, dea	th occurred	d at the time,	, date ar	nd place, an	ner as st	ated. the cause	e(s)
	To the To the To the To the Comp	ğ	29b. Signature and title of certification	er			29	c. License	number			29d. Da	ate signed (	Month,	Day, Year)	)
			▶ Nove E €				1	000	588	1-4	-	C	3/1/	40		
	T.		30. Name and address of person	who completed cause	of death (Item	n 23a) (Tvpe.	Print)		- 0 0	<b>V</b> (		•	21.1			
_	8		DEL E. LATTI	N, M.D	101 Co	LONIA	LW	ay.	Ris	ing	Sun!	MO	210	411		
	Sta Regist	- 6	31. Date filed (Month, Day, Year MAR 1 & 2010)	32. Re	e of death (Item	are and		4,		- 4						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ March Eugene William Hinds 10, 9:15 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4321 Mt. Olney Lane Olnev Montgomery Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ Months Days Hours Aug Year 940 249-58-0951 69 South Carolina **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4321 Mt. Olney Lane 20832 IISA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Year or Dates 1959-65 Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Director Insurance Be 17. Father's Name (First, Middle, Last) Nathan H. Hinds 18. Mother's Name First, Middle, Maiden Surname) Belle Pace ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gail Hinds/Wife 4321 Mt. Olney Lane, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State March 2010 17 Norbeck Memorial Park 4 Donation 5 Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licenses 22.Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ORONAR years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 2 🗌 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1  $\square$  Yes 2 🗆 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hyde

GREGORY

MARCH 10, 2010

PRINCE Philip Drive, Olivey, MARYLAND 2087

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Chard Hay NIKINS 7.0 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Copper Ridge Nursing Home Carroll Sykesville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 0971071922 Director 215-12-7894 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Montgomery Gaithersburg 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 18801 Watkins Mill Road 20879 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1943-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify: Completed 1945 Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 7th Construction Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel R. Hawkins Ethel Prather Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Healtl
Important: If item 2:
any injury or other t
once. 18801 Watkins Mill Road, Gaithersburg, MD 20879 <u>Gertrude Hawkins - wife</u> 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 3/18/10 Gaithersburg, MD Brooke Grove Cem. 4 ☐ Donation 5 ☐ Other (Specify) Snowden Funeral Home Signatur Funeral Service Lin 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 ications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. 23a. Part 1. Enter the dise shock, or heart failure. ase, or comple. List only Onset and Death Immediate Cause (Final Physician/ ementic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner as Sequentially list conditions, Je. cause. Enter Underlying Exami burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown rate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 □ Probably 4 □ Unknown Completed 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy certificate 1 Yes 2 No 2 1 No Yes
 Yes
 ✓ 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🔲 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Matural 5 Pending injury 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 114 Business Center Drive, Resisterstown, MD 21136 Thomas J. Vento, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 16 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Hermann Hagedorn March 6:55 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery National Lutheran Home Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Nov. 5. 1919 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Gountry) Michigan Director Yrs 90 **577-**07**-**6828 Nov. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "nature!" any injury or other traumatic average. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 240 Rolling Road 20877 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

☑ Yes 2 □ No 1946-Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed 1948 Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Postal Service Letter Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Hagedorn Emma Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie L. Maul/Daughter 240 Rolling Road, Gaithersburg, Maryland 20877 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 3/12/2010 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital. 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural الاست. "A within 24 hours ane المدادة".

• To the Funeral Director: Afte Funeral Director: 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5+1

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signature

-970

VEIRS DRIVE, ROCKVILLE, N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

16

ARESH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9<sup>Day</sup> 2010 ear Physician/ Hinnant Hill **Mildred** March 7:45 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges 5811 Justina Drive Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 **X** F Days Hours May 10, 88 579-20-7777 1921 Washington, D.C. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Prince Georges Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral United States 20706 5811 Justina Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 XWidowed 4 Divorced Year or Dates af Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done (life. DO NOT use retired) (Specify only highest gr rade completed during most of working District of Columbia Elementary/Seconday (0-12) College (1-4 or 5+) be filed within Public Schools 6 years Educator d other f Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked or traumatic ever Page 1 and 2 should be file ment of Health and Mental ant: If item 27 is marked o ည Hattie Jackson Luther Hinnant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Harrison Drive; Evans, Georgia 30809 Johnny Richard Lowe (Guardian) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 16 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 

Burial 2 □ Cremation 3 □ Removal from State Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery Signature of Funeral Se 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires Records, icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 🗌 Yes 2 🎒 No Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify 2 🗶 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 🗶 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of o

John Allen Reilly,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.;

32. Registra s Sign

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

March

801 Tollhouse Avenue; Suite D1; Frederick, Maryland 21701

2010

# Hallingsworth, Danglow

			For	State of N	/larylan					and M	lental Hy	giene	20	10	00757
			Registrar	1		Cer	tificate	e of D	eath			Reg. No	<u>4</u> U	1 U	09131
	Physicia	n/	1. Decedent's Name (First, Middle, Last		_						Date of De Month	Day	у	Year	3. Time of Death
	Medic	al	Donald Raymond			<u> </u>			I/I iiu		Marci			1010	1625 M
	Examin	er	4a. Facility Name (if not institution, give					,	Location o		3 - 0			of Death	_
			Memorial Haspe 5. Social Security Number 6. Se			ast birthday)	If Under		n, Maryland Talbot If Under 24 Hrs. 8, Date of Birth 9, Birthpl					lace (State or Foreign	
	Funeral Director		316-30-1127	M 2 □ F	76	Yrs.	Months	Days	Hours	Min.	12/22/			Count	
			Usual Residence of Decedent		, 0						12/22/	1755	33   011		
	and sho	tor	10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside City Limits
	Mary 28a-f stifie	Director	MD Kent		Ke	nnedyv	ille								1 🗆 Yes 2 🔀 No
	a or the	O E	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of V	What Coun	try?
	is 23	Funeral	12067 Kennedyvill	e Rd.			2.	1620				US	SA		
	death item ner n		11. Marital Status	<ol> <li>Was Decedent</li> <li>Apped Forces</li> </ol>	?	S. 13. V	Vas Deced f Yes, spec	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			e - America	
36	after I", or cami	b	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ♣ Yes 2 [ If Yes, Give	∃ <sub>No</sub> Korea		I ☐ Yes							Whit	
21215-0036	ours atura	Completed by	15. Decedent's Ed		Korea Confl	16a. Deced	lont's Have	l Occupa	tion	_					
5	72 h n "n Aedio	현	(Specify only highest gra	de completed)		(Give I	kind of wor O NOT use	k done di	uring most	t of workir	ng	16b. Ki	ind of Bi	usiness Inc	lustry
72	vithin iene. rr tha		Elementary/Seconday (0-12)	College (1-4 or	r 5+)	I	e Tro	,	:			La	w Ei	nforc	ement
ō	iled v I Hyg o <b>the</b> rent,		17. Father's Name (First, Middle, Last)					Ī	18. Mothe	er's Name	(First, Middle,	Maiden	Surname	e)	
<u>a</u>	l be f lenta rked tic ev	မ	Ray Hollingsworth	1					Arm	illa	Gebele	<u> </u>			
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ore	of Hill of Hill if iter		20a. Method of Disposition  1 🔀 Burial 2   Cremation 3	Demoval from Sta	20b. F	lace of Dispo emetery cren	sition (Nan	ne of ther place	e)		)ate	20c. Lo	ocation -	City or To	wn, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify		Eas	emeter	У			3/20					rket, MD
3alt	permit Depart Import any inj once,		21. Signature of Funeral Service Licens	e / /		22 F	Name an	d Addres	s of Facilit	y nbei:	n & New tertown	mam	Fune	eral	Home
_	<u></u> □ □ = α ο		suk y y	Gentre	w	1	.30 S <sub>I</sub>	peér	Rd.	Ches	tertown	, MD	216	620	
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F	Trysician/		Immediate Cause (Final disease or condition	a. Adva	MClo	d Hu	epal	10 Cl	llul	al	Carcin	D200	<u>a_</u>		Onset and Death
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Division of Vital Records,	al or A s after I Direc d in by		4 - Homicide determined	building, e	etc. (Specify	1)					City or Tov	vn, State)			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier Certifying Phys	ician: To the best	of my know	ledge, death	occured at	the time,	date and	place, and	d due to the ca	use(s) an	d mann	er as state	d.
	the Hi nin 24 the Ft helete	Mec	only one) 3 Certifying Nurs												ise(s) and manner stated ated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State
Registrar Amend #4prefuneralhome3/23/Quertification Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15 201 0 March 2:22 am Meloy Hester Sr. Gordon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 06 7. Age (In yrs. 57 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) VA 1 XM 2 □ F Months Days Hours 229-80-6049 0270971953 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at Director Prince George's Upper Marlboro 1 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 9137 D'arcy Road items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. should be filed within 72 hours after c and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 N Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Counseler Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geneva L. Overbey Thomas E. Hester permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4831 Hawkwood Trail Winston Salem, Phyllis Martin/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Dakhurst Cemetery 3-20-2010 Clarksville, VA 21. Signature of Funeral Service Ligensee permit. 22. Name and Address of Facility C.H. Harris Funeral Home Clarksville, VA 23927-0745 Box 745 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a co Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed Hospital or Attending Physician: The this certificate 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 5 Pending 1 Natural injury within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License numbe rson who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mont)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09759 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wanda Annette Hull 1620 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PENIN SULA 34213640 HICOMICO ROGIONAL Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** MD ountry) 1 □ M 2 🛣 F 7-15-1941 Months Days Hours Min. 216-38-7990 68 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Wicomico 1 ☐ Yes 2 No Tyaskin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Tyaskin-Nanticoke Road 21865 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 24 No Black, White, etc. ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Tax Dept. Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alexander Boykin Christine Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Wynnette Curtis 4321 Tyaskin-Nanticoke Rd, Tyaskin, MD 2186\$ 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 3/20/2010 Grace UMC Cem Newtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ estive ceri disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No page 2 400 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 4 No 1 Inpatient 2 ER/Outpatient 3 I DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ( 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinest: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. United States of the cause (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1067778 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 144 awall St ishum MD 31. Date filed (Month strar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18, Day March 2010<sup>ar</sup> 23:33 Henry Joseph Hartwick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Research Road, Unit F Prince George's Greenbelt 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹M 2 ☐ F Months Days Hours Min. North Carolina Month, Bay, Year) June 8, 1944 Director 217-42-2179 65 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified Prince George's Maryland Greenbelt 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20770 3 Research Road, Unit F United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White f Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Engineer Communications Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Hartwick Anna Hanich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Hartwick -wife 3 Research Rd., Unit F Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenbelt City Cem. 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/23/2010 Greenbelt, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MINUTES Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary artery Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined fillec 24 hours Medical 29a. Certifier Certifying Physician: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis, if examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner of the best of my knowledge, death occurred at the time; date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 19, 2010 D05568 COD M ≥> 30. Name and address of person who completed cause of death (It is a large) ype, Print)
Samuel B. Itscoitz, M.D. 10313 Georgia Avenue, #306 Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09761 State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2:00 PM 2010 March Wilbert C. Jones Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Fort Washington 11900 Ambrose Ln. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday **Funeral** (Month, Day, Days Virginia 925 Nov. 227-20-6976 84 Director Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 X No Fort Washington Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 U.S.A 11900 Ambrose Ln. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No WWII Yes f Yes, Give "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Developer Real Estate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Coleman Burrell Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11900 Ambrose Ln. Fort Washington, MD 20744 Edith Jones (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State MD Veteran's Cemetery 3/25/2010 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 21. Signar re of Funeral Service License 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Leath Immediate Cause (Final (o hour Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and defeached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 9 Unknown 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown been si Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Tyes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Natural 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUREL

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Registrar's Signatur

MAR 162010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0313 2010 11:18A M Naomi T. Jacobs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 307 North Blvd. Wicomico Salisbury 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🛣 F 11 12 1911 Director Virginia 231-10-8085 98 Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 May Yes 2 ☐ No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307 North Blvd. 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 XWidowed 4 Divorced White Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Office Worker US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sol Liebman Corinee Fass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6124 Robinwood Rd., Bethesda, Maryland 20817 Sylvan Karlin|nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Beth frame Cemetery 3 | 15 | 2010 Salisbury, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 42. Name and Address of Facility HOLLOWAY Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athleroskiotic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of ng physician and as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has , page 2 s autopsy performe After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☑ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ■ Residence 6 □ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Records, P.O. the Hospital or Attending Physician; The law Division of Vital within 24 hours after deat To the Funeral Director:

WP

Registrar

Medical

29a. Certifier

(Check

only one 29b. Signature

MO

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Month Physician/ Khatoon Nasima 10:17a M March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Baltimore Baltimore Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 MAY 02 Year) 934 Days Hours Min. India **Director** 217-33-7561 75 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MDAnne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 United States 1332 Anglesey Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify: 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Syed Manzar Hasam Sarah Muniba Syed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1332 Anglesey Drive Davidsonville, MD 21035 19a. Informant's Name/Relationship (Type, Print) Syed Ahmad Zia / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/14/2010 Laurel, MD 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 7 Park Avenue, Gaithersburg, MD 21. Signature of Funeral Service Licensee dece M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sequence of Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ned by the a e detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò signe I be d Records, 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopsy performed' 2 X N To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 38 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 rain State Registrar

Box 68760

of Vital

Division

		- State Registrar				Ce	rtifica	ate of	Death	7		Reg. No.	.ZU	1 U	09	10
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Funeral		5. Social Security Number	6. Sex	/ 7.	Age (In yrs. i	ast birthday	If Un	der 1 Year	If Unde	r 24 Hrs. Min.	8. Date of Bi	irth		9. Birthp	lace (State	or Foreigi
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PEGGY ANN KENNEDY Physician/ MARCH 3:20 AMM 20°10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death LINTHICUM Examiner 4c. County of Death
ANNE ARUNDEL HOSPICE OF THE CHESAPEAKE 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 05-05-1947 5. Social Security Number 212–48–8080 6. Sex **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 🗆 M 2 💢 🦹 Hours 62 MARYLAND Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE CITY N/A 1XX es 2 ☐ No 10e. Street and Number 10f. Zip Code 10q, Citizen of What Country? 23a Funeral 2409 SMITH AVE., 21227 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes XXNo Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
MAID TO PERFECTION (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 1 2 T H College (1-4 or 5+) HOUSE CLEANING COM PROFESSIONAL MAID Be and 2 should be file.

tt of Health and Mental Hy
If item 27 is marked
other for 18. Mother's Name (First, Middle, Maiden Surname) HARRY ROBERT KENNEDY MARY MACKENZIE KARCHER 19a. Informant's Name/Relationship (Type, Print)
GINNY LANE / SISTER ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SMITH AVE., BALTIMORE, MARYLAND 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite MARCH RIVERDALE PARK CREMATORY 1 Burial 2XXCremation 3 Removal from State RIVERDALE, MD 16, 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee JOHNSON FUNERAL SERVICES, PAPLAINS LANE, WHITE PLAIRS, PAD TERRENCE L. JOHNSON#M00993 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Prysician/ MeTastat am mu lar disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). and I-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
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To the Funeral Director: Af
completed filled in by the fu 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29d. Date signed (Month, Day, Year) 2010 Foerson who completed cause of death (Item 23a) (Type, Print)
SIDHU, M.D., 208 CRAIN HIGHWAY, GLEN BURNIE, MARYLAND 21061 31. Date filed (Month, Pay, Year) NAR 16 2010 Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Jake

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State Registra AMEND#20bperFH, 3/18/10, BMW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 March 10, **Physician** 11:59PM SEYMOUR HAROLD LIPSHITZ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 01ney Montgomery Montgomery General Hospital | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | April 28,1919 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** 1 XM 2 □ F 121-10-9727 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evancines must be notified at 1 ☐Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3701 International Drive United States by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐Yes 2 ☐ No
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Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Logistics Expert Department of the Navy 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Lipshitz Rose Levinthal ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8310 Lyndhurst Street, Laurel, MD 20724 Bonnie Dodd (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 15, 2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Unknown -22. Name and Address of Facility DeVol Funeral 21. Signature of Funeral Service Licen 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that aused the deal shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, newmon, a Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin.
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ∃Yes 2 🗆 No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 52660 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s perform 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No Attending Physician: ar death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendir
within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records,

State Registrar

10+1

Medical

31. Date filed (Month, Day, Year) MAR 16 2010

29b. Signature and title of certifier

(Check only one)



Wo have 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 13. Day 2010 Year Nancy Marie Lilly 6:50 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Health & Wellness Ct Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🖺 F Min. Hours Jumeth Bay, Yell'937 578-48-3292 72 Illinois Director Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 20910 10e. Street and Number 2232 Washington Avenue, #101 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Consultant Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve and and the second the second ည Edward Paul Lilly Nancy Marie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin John Lilly/Brother 13122 11th Street, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State March 2010 17 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death few years Physician/ Chronic Obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsv performed' death? Yes 2 X No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4x Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D38262 March 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mendhiratta, MD 2401 Research Blvd. #330, Rockville, MD 20850 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 39am 2010 Verdia Phillips Lewis March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** a Plata If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Days 100 Yrs. 1909 577-30-7029 South Carolina Director May 4, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maxical Examiner must be notified at MC-464708 1 XYes 2 □ No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20001 United States 1050 New Jersey Avenue; N.W.; Apt.310 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black altimore, Maryland 21215-0036 1∐Yes 2**X** No Specify: ģ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Office Buildings 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Bell Simms William | ပ 19a. Informant's Name/Relationship (Type. Print)
(Great Granddaughter)

Stephanie Inez Pearson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4640 Sheffield Circle; Waldorf, Maryland 206 Department of Health a Important: If item 27 is any injury or other trainonce. 4640 Sheffield Circle; Waldorf, Maryland 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland Lincoln Memorial Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Lic Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pertensive 14 Cardio Voscular disease or condition resulting in death) /Medical (or as a consequence of): Examiner Concretive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) P.O. | s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 12 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No spital or Attendinours after death.

neral Director: A investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 11, 2010

W23

State Registrar

Registrar
DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Into Figs by All Gopies Are Legible.

Amend Items 11619a Per Info Figs by All Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Caitlin Stephens Laird 2010 7:47 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days 1 □ M 2 🎗 F Hours 213-27-5970 1076/1984 25 MD **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12011 Grays Corner Rd. 21811 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed 3 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bain W. Laird Amy Hall 19a. Informant's Name/Relationship (Type, Print)

Ramil Lyaushin/husband

Balli W Leite / Isticher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12011 Grays Corner Rd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No 1 🗌 Yes Yes To Be 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes Natural 5 Pendina 2 🗌 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: ign: to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

r: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examin 3 Certifying Nur ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier signed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylar	-				Mental Hy	giene	10	09770		
		T = State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  2. Date of Death											To 7 / 2 //		
	Physicia		Esther F. Luz	,						Month Mar.		20 <sup>Year</sup> 0	3. Time of Death 5:10a <sup>M</sup>		
	Medic Examin		4a. Facilify Name (if not institution		ber)	····	4b. City, To	wn, or Location	of Death		4c. Count		<del></del>		
-30	1		164 Boatyard					apeake			Cec	i1	-		
	Funeral Director		5. Social Security Number 215–28–4710	6. Sex 1 □ M 2 <b>X</b> □ F	7. Age (In yrs. i	81 Yrs.	If Under 1 Months L	Year If Under Days Hours	Min.	8. Date of Bir (Month, Da Apr. 14	th <i>y, Year</i> ] • 1928	9. Birtl Cou	nplace (State or Foreign Intry) MD		
	and show at	o	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Loc	ation						10d. Inside Cify Limits		
	Maryla 28a-f	Director	MD Ceci	1	Che	sapeak	e City						1 ☐ Yes 2X☐ No		
	h the	a D	10e. Street and Number		•		10f. Zip Co				10g. Citizen of	What Cou	untry?		
	ith wit ms 23 must	Funeral	164 Boatyard R	d •		0 140.11	219				USA				
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d 2	iled within I Hygiene. other tha	Be	17. Father's Name (First, Middle,	Last)		11001		18. Mot	her's Nam	ne (First, Middle,	Maiden Surnam				
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Baltimore, Maryland	of Health and Mental File of Health and Mental Fitem 27 is marked or rother traumatic even		19a. Informant's Name/Relations Nicholas Luzet		1	-				r, City or Town, S		•			
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that ca	aused the deat th line.	h. Do not ente	r the mode o	f dying, such a	s cardiac	or respiratory an	rest,		Approximate Interval Between		
-4	Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)  a. Altheimers Demention Due to (or as a consequence of):												
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	cate be executed physician and the burial-transit	alE	resulting in death) Last	Due to (d	r as a consequ	uence of):									
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		ant at time of o		Other (speci				М	onth	Day Year		
P.0	that the ned by detact	by Pr	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	nderlying cau	se given in Par	t I.	23e. Did to	bacco use cont	tribute to	the cause of death?		
ds,	w requires that is been signed be should be deta	ted t	Coronary	artery	dise	47				1 🗆 '	Yes 2 No	3 🗌 Pro	obably 4 🗌 Unknown		
cor	aw rei as be	Completed								24a. Was autop	osy	prior to c	opsy findings available ompletion of cause of		
Re	ician: The law certificate has rector, page 2.	Con								perfo		death?	2 🗆 No		
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ivisi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of	of Injury - At ho g, etc. (Specify		et, factory, of	fice		28f. Location (S City or Tow		er or Rura	al Route Number,		
	ospita hours uneral ed filler	Medical	29a. Certifier 1 Certifying	Physician: To the be	st of my knowl	ledge, death o	ccured at the	time, date and	place, ar	nd due to the car	use(s) and mann	er as stat	ed.		
	the H hin 24 the Fi	Me	only one) 3 L Certifying	Nurse Practioner: To	the best of my	knowledge, d	eath occurred	at the time, da	te and place	t the time, date a ce, and due to the	nd place, and du e cause(s) and m	e to the ca anner as s	ause(s) and manner stated. stated.		
	5 vii vii		29b. Signature and title of certifier  Robusta M	Presta Da	115			cense number	7 -	1	29d. Date signe		Day, Year)		
	<i>,</i>		30. Name and address of person			23a) (Type, Pi			, ,		3/15/	,0			
	6		Robert A.	m dal-		2		H.965	+ Su	te 214,	Eltton	MO	21921		
	Stat Registra	e ir	31. Date flad (AR) 1 Day, Year)	32. Re	gistrar's Signat	de la									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 13 Day 2010 Year Physician/ 7:30 William B. Ledford ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8539 Abell Way Charles Waldorf Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Days Min. 1 XM 2 □ F 212-66-7277 May 22,1955 Washington D.C. Director 54 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles Waldorf 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8539 Abell Way 20603 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Mechanic Body Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maurine Linkous William B. Ledford, Sr. and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8539 Abell Way, Waldorf, Md. 20603 1 and 2 s of Health i Christine J. Ledford Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) March 15, Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ₽ 2010 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility. Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, 21. Signature of Funeral Service Licens M00668 20640 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter ease, or complications Approximate Interval Between shock, or heart illure. List only one cause o School Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day been signed by the a should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform hours after death.

neral Director: After this certificate Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 횬 Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural
Accident 5 Pending work' 1 Yes 2 🗆 No Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check

29b. Signature and titl

certifier

\$100/A# 103

Capatying Nurse Practioner to the best of my knowledge

who completed ocuse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15:15 P. M 2010 NADIJA N/M/NLEMKO march /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death Examine SIG 29 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, APRIL Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 924 1□ M 2□√F Months Days Hours Min UKRAINE 85 Director 219-82-2502 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Exarts increust by riviffied at Director MD. CHARLES 1 ☐ Yes 2 No PORT TOBACCO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O.BOX 444 20677 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMFARM WORKER 3rd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown KRAJEWSKI BRONISTAWA MIROWSKA ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7675 CAROL ROAD PORT TOBACCO, MD. 20677 WILLIE LEMKO-SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 3-26-10 ALEX., VA. permit. 21. Signature of Juneral Service License 2. Name and Address of Facility M00479 RAYMOND FUNÉRAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Med 23a. Part 1. Enter the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMON Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CHO CHO. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cates (Listed events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Yea signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ ficate has been sind, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performe Division of Vital 1 ☐ Yes 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral ( Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c\_License number 29d. Date signed (Month, Day, Year)

State Registrar 30 Name and address of person who

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Body Las

leted cause of death (Item 23a) (Type

rar's Signature

32. Regi

	ľ	For State Registrar	State of Ma	aryland			nt of H te of I		ind Me		iene :g. No.				
Physici /Medic		Decedent's Name (First, Middle, Las     JAMES EDWARD	<sup>t)</sup> McLaurin							Date of Death Month arch 14	Day -	V <sub>ea</sub> D LO	3 Time of Death 3		
Examir		4a. Facility Name (If not institution, give Shady Grove Adven	,	ital			y, Town, or ockvi	Location of 11e	Death			nty of Death	у		
Funeral Director		5. Social Security Number 372-38-2461 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1 If Under 24 Hrs. 2 If Under 24 Hrs. 3 If Under											place (State or Foreign vtry) issippi		
f show	'n	Usual Residence of Decedent	ory		Town or Lo						10d. Inside City Limits 1 ∐Yes 2 X No				
with the Na aor 28a-	Funeral Director	10e. Street and Number 11624 Doxdam Terr		Gel	mancov		ip Code	0876			-	of What Cour			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination is confilled at once.	by Funera	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:		8-		edent of H ecify Cuba 2 XNo	ispanic Orig in, Mexican, Specify:	jin? (Specif Puerto Ric	fy Yes or No- can, etc.)		Race - Americ Black, White,			
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Exandram must be rodiffed at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Boiler Operator Heating								ess/Industry		
id be filed w ental Hygie ked other ti ic event, to	To Be Col	12   17. Father's Name (First, Middle, Last) Lawrence McLaurin	DOTTE	18. Mother's Name (First, Middle, Maiden Surna Cora Garrison							<del></del>				
and 2 shoul ealth and M n 27 is mar er traumati		19a. Informant's Name/Relationship (7			11624	4 Do	xdam	Terra		Route Number,	vn, MI	2087	6		
Pages 1: ment of He lant: If iten jury or oth		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City										-			
permit Depar Impor any In once.	U	21. Signature of Funeral Service Liten	1 Joel		10	) Ea	st De	er Pai	rk Dr		nersbu		D 20877		
Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on end in line.  Acute I  Due to (or as a	Муоса	rdial				cardiac or r	espiratory arre	est,	1	Approximate Interval Between Onset and Death Minutes		
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icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Ischem			opa	thy						Years		
or Attending Priystcian; The law requires that the death certilical affect death.  After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal	death 3□	] Ectopic ] Other (	pregnanc	у				Date of deliv Month	ery Day Year		
quires that in signed build be deta	þ	Try north and in a													
The law requir cate has been si page 2 should I	Completed	AICD Implantation	1							24a. Was ar autops perform 1 🗆 Yes 2	y ned?	b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No		
nysician; The	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2 TVF	ER/Outpatier	t 3□1	Oth	or.		Check only one		Other (Speci	6()		
ending Phy eath. or: After this he funeral c	<u> -    </u>	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	ry	28b. Time of Injury		28c. injur Work		280	d. Describe ho			·//		
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	:. (Specify,	) 					City or Town	, State)		al Route Number,		
ne Hosp n 24 hou ne Fune pletely fi	Medical		ysician: To the best of iner: On the basis of and manner sta	f examinati											
Z T	2	29b. Signature and title of certifier	Z M	D		2	9c. Licens D37			29	-	n 14,			
3)	4	30. Name and address of poson who of Dr. David G. Srou					Cente	r Dri	ve R	ockvill	Le, MI	2085	0		
Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ure		1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 0 1 0 Bennie Lee McKinney March 11:53am Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Month, Day, Year) 01/05/27 S Country) Director 248-42-7996 83 Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits Largo Prince George' MD. M Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral with 23a 1002 Trebing La 20774 USA items ; death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Al Hygiene.
A other that Elementary/Seconday (0-12) College (1-4 or 5+) Holy Cross Radiology Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Emmie McKinney Joe Ben Dukes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann McKinney Wife 1002 Trebing La Largo, Md 20774 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Suitland, Maryland 3/24/10 4 ☐ Donation 5 ☐ Other (Specify) Lincoln 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Snead Mortuary 1409 Fairlakes Service, P.A. 0777 Mitchellville MD 23a. Part 1. Entertifie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) oronary Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 Yes 2 this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 2 No ျ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mangler of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After 28d. Describe how injury occurred 1 2 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Physician/ Month Cleon Ernestine Martin $A^{M}$ 12 March 6:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** . Social Security Number 577-22-2288 1 □ M 2 🕱 F Months Days Hours Min. Virginia 10/22/1922 Yrs. Director 87 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 🗌 Yes 2 🍱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21704 8285 Elaine Way United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Black, White, etc. Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Eugee White Cleon Denty traumatic 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health as Important: If item 27 is any injury or other treas 8285 Elaine Way, Frederick, Maryland 21704 Bonnie Carol Woodward (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 15, Columbia Ga Cemetery 1 XBurial 2 Cremation 3 Removal from State . Gardens 4 Donation 5 Other (Specify) 2010 <u>Arlington. Virginia</u> 22. Name and Address of Facility DeVol Funeral Home, Signature of Eurieral Service License MO0689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or bearf failure. List only one cause on each line. shock Interval Between Immediate Cause (Final Onset and Death Myocardial Infarction Physician/ Minutes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Organiant at time of death 5 Other (specify) \_\_\_\_ IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 ☐ Yes 2 🔀 No 9 ☐ Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 \( \text{Yes} \) 2 \( \text{No} \) No 24a. Was an page 2 s autopsy performed? Yes 2 2 N has or Attending Physician: The certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural Accider work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: the Suicide 6 Could not be 3 ☐ Sulciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 $m_{\mathcal{G}}$ 

32. Registrar's Signature

alana

mit

31. Date filed (Month, Day, Year)

D0064068

Medical Center Drive

2010 20850

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	1aryland		artment of H			21	110	09776		
	Physicia	n/	Registrar  1. Decedent's Name (First, Middle, La.  Susanna	st) McColl	11M	061	incate of b	Catri	2. Date of Dea Month <b>March</b>	_	010	3. Time of Death <b>1:52 A.</b> M		
~	Medic Examin	al	4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Death			y of Death	1:32 A. M		
	LAGIIIII	CI	National Lutherar		Rockv	ille	* * * * * * * * * * * * * * * * * * * *	cville			ntgom	ery		
	Funeral Director		243-01-4070	Sex	ge (In yrs. Ia: <b>88</b>	st <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day <b>March</b>	h /5,1922	9. Birthp Count <b>Nort</b>	lace (State or Foreign try)  Carolina		
	ind show at	ō	Usual Residence of Decedent  10a. State 10b. County	· ·	10c. City	, Town or Loc	cation				11	0d. Inside City Limits		
	Maryla 28a-f s otified	irect	Maryland Montgo	mery	]	Rockvi	11e					1 <b>X</b> Yes 2 □ No		
	th the 3a or t be n	Funeral Director	10e. Street and Number  9701 Veirs Drive				10f. Zip Code 20850	n		10g. Citizen of <b>United</b>		'		
	eath w	-une	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. V	Vas Decedent of His Yes, specify Cubar		pecify Yes or No-		ce - America			
9	ifter de ", or it amine	by	1 X Never Married 2  Married	Armed Forces? 1  Yes 2  If Yes, Give	No No		f Yes, specify Cubar  ☐ Yes 2 <b>X</b> No		o Rican, etc.)		ck, White, e			
9500-61212	within 72 hours after giene. ier than "natural", or the Medical Exami,	Completed	3 Widowed 4 Divorced  15. Decedent's E	Year or Dates.	1		lent's Usual Occupa			16b. Kind of E				
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	d with tygien ther th	Be Co	17. Father's Name (First, Middle, Last)	4 years	,	Writ	er Editor		(F) 1 4 4 1 1 1	Admini		ion		
yland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	<b>To B</b>	' ' '	McCollum				18. Mother's Nar <b>Kathe</b> :	ne (First, Middle, rine S	<sub>Maiden</sub> Sumam <b>herdian</b>				
Mary	should be file n and Mental I <b>is marked o</b> <b>raumatic</b> eve		19a. Informant's Name/Relationship (1	ype, Print)		19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Numbe	, City or Town,	State, Zip C	ode) 20772		
ტ 	1 and 2 s of Health item 27 other tra		Vanessa A. Shorte	r (Niece)	20h Pli		Lord Fai			r Marlb 20c. Location				
saitimore,	age 1 ent of l nt: If it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		e ce	metery, cren	natory or other place <b>coln Ceme</b>		ch <sup>ate</sup> 19,		•	aryland		
altii	mit. P partm portar y injur		21. Signature of Funeral Section Like		1 -			-				orticians,		
מ	9 9 m m 9		Landaph	D. Hours		In	c.;600 Ke	ennedy St	treet,N.	W.;Wash	_	n,D.C.20011		
7	Physician/ Medical Examiner	50 Z	23a. Part 1. Enter the disease, or com shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)	one cause on each ling.		onic	r the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death		
00	e be executed sysician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initiary that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
. Box 68/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral after death.  To the Funeral afteretors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown			23d. Date of delivery Month Day Year							
ν, γ. Ο.	ires that t signed b d be deta	by	Part II. Other significant conditions of	ontributing to death	but not resu	ılting in the u	nderlying cause give	en in Part I.				e cause of death?		
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0	g Phy: er this neral di	te: To	27. Manner of Death	1 ∐ Inpat 28a. Date of inj (Month, Da	ury 2	R/Outpatien 28b. Time of	28c. Injury	at	ome 5 Resid					
VISION	tendin eath. or: Aft the fur	ifica	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	n	iy, rear)	injury	M 1 □	Yes 2 No						
<u> </u>	l or Att after d Direct d in by	Certificate:	4 Homicide determined	28e. Place of In	jury - At hon tc. (Spec <i>ify</i> )	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,		
1	e Hospita 124 hours 5 Funeral leted filled	Medical (			examination	and/or invest	igation, in my opinior	n, death occurred a	at the time, date a	nd place, and du	e to the cau	se(s) and manner stated.		
	To the within To the comp	2	29b. Signature and the of certifier	0			29c. License	number		29d. Date signe	d (Month, E	Day, Year)		
	,,		famel	1 mo	ller	mp	Do	05061	2	March	12	,2010		
2	. 4		30. Name and address of person who a	HERM.	death (Item 2	23a) (Type, P <b>701 U</b>	rint) ICICS De	INE RO	ckville	maryla	me :	20850		
	Stat Registra	•	31. Date filed (Month, Day, Year)  NAR 1 7 2010	32. Regist	ar's Signatu	re de								

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:30P M L. Mildred 2010 Mulvin March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 99 213-38-0546 29 1910 Pennsylvania Dec. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2 No 01ney Director Md. Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19705 Gray Heaven Manor Road 20832 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyglene. Important: If Item Z7 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner one. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. Specify: þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public School Teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Childs Η. McLallen Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20832 19705 Gray Heaven Manor Road, Olney, Md. Lucinda Mullally / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/10/10 Alexandria, Virginia Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home X P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wee Physician neumone /Medical Due to (or as a consequence of) Examiner creent Sequentially list conditions, if any, leading to first datacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Dementia 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician; The law requires that the death certificate be executed after death n 24 hou... the Funeral Dir completely within 24

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 04115

of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENUE ERT BIRSCHBACH, M.D. GAITHERSBURG, MD. 2087

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature Charma

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State of M	larylan		artment of H r <i>tificate of L</i>		nental Hy	gien/ Reg. N	20	10	09778
Division		1. Decedent's Name	e (First, Middle, La	est)					2. Date of D	eath			3. Time of Death
Physicia /Medio		Ruth		jomery					March		<sup>ay</sup> 2010 <sup>Y</sup>		5:34 рм
Examin	er			re street and numbe ledical Ce				Location of Death			c. County of <b>Prince</b>		orge
Funeral		5. Social Security N	lumber 6. 9	Sex 7. A		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi				place (State or Foreign
Director		249-50-42	249	1□ M 20XF g	5	Yrs.	Months Days	Hours Min.	Sept.1				h Carolina
and w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
Maryl I-f sho	tor	Maryland	Prince	George	Ac	cokeek							1 □Yes 2 No
or 282	Sirec	10e. Street and Nur	mber				10f. Zip Code			10g. (	Citizen of Wh	at Cour	ntry?
ath wi	ral	15505 Liv	vingston	т			2060				U.S.A.		
ter de items	Funeral Director	11. Marital Status	ied 2□ Married	12. Was Deceden Armed Forces 1 [Yes 2 ]	2	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,	Mhite,	
urs af al", or Even	by	3 ₩ Widowed		If Yes, Give Year or Dates			1⊡Yes 2⊡XNo	Specify:			Specify:	Bla	ck
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland in Mahala Hygiene. I have smarked other than "natural", or items 23a or 28a-f show umatic event, I'm Medical Evantination institut to notified at	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing	16b.	Kind of Busin	ness/In	dustry
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il Hygi other ent, I	Be Co	17. Father's Name (	(First, Middle, Last	")		11044		18. Mother's Name	e (First, Middle	e, Maide	en Surname)		
uld be Venta rrked ttic ev	To B	Frank Rok	oinson					Dora	Loadhol	Lt			
2 sho r and is ma is ma		19a. Informant's Na	- '			1	ng Address (Street						
1 and Health em 27 ther t		Yvonne Gi 20a. Method of Disp		Daught			Livingst				Location - Ci		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If the Halth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Marileal Eventination: unit be notified at once.		1 <b>∏∛</b> Burial 2 [		Removal from State	Pa	meccc	sition (Name of matory or other plac os Cemeter	- Y ¦		Col		•	uth Carolina
permit. Depart Import any Inj once.		21. Signatur of Fu	ineral Service Line	nsee	M00	668 Å	Name and Address Villiams 1 270 Hawth	Suneral H	ome, P.	A.	A bea	<i>M</i> -3	20640
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/Medical Examiner		resulting in death)	(	Due to (or a									
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eath certific attending p for use as i	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant									23d. Date of delivery		
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ding Physiclan: The n. After this certificate h funeral director, page	Be C	25. Was case referrexaminer?						26. Place of Deat	1 □Yes h (Check only		NO IL	1162	2 🗆 NO
Physic this co		1 ☐ Yes 2 🖫		Hospital: 1 ☐ Inpa		ER/Outpatier		4 LI Nursing Ho					(y)
ding I h. After funer	tion:	27. Manner of Death 1 Natural	n 5 □ Pending investigatio	28a. Date of Ir (Month, L	jury Day, Year)	28b. Time o Injury	Work	yat <br Yes 2 □ No	28d. Describe	how in	jury occurred	í	
Atten r deat ector: by the	ertification: To	2 Accident 3 Suicide	6 Could not b	e 28e. Place of I	njury - At ho	me, farm, str	eet, factory, office	103 2 (110	28f. Location	(Street	and Number	or Rura	al Route Number,
tal or	Cert	4 Homicide	. /	bullaing,	etc. ( <i>Specif</i>	y)			City or To	own, Sta	ire)		
To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)		hysician: To the bes miner: On the basis and manner:	of examina								
To the complete	Me	29b. Signature and	title of certifier	0			29c. License			29d. [	Date signed (	Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death R McDermott Physician/ Daniel <sup>D</sup>1<sup>y</sup>1, 2010 1:30 P M March Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Prince George's Clinton 6105 Woodland Lane Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours June 25, 1936 222-20-6851 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's Clinton 1 🗆 Yes 2 🔀 No 10g. Citizen of What Country?
USA 10e. Street and Number 10f. Zip Code Funeral 20735 6105 Woodland Lane 12. Was Decedent Ever in U.S. Armed Forces?

XIX Yes 2 □ No
If Yes, Give Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3√ Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Construction Iron Worker 9 + hBe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ Margaret Chambers Fred Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6105 Woodland Lane, Clinton, MD 20735 (Son) John A. McDermott 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3-16-2010 Fort Lincoln Cemeter Brentwood, Maryland 21. Sign to a f Funeral S vice I conse 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Use Birth 2 Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) in the past 12 months? Day Month Year Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 ☑ Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? certificate | 1 Yes **Division of Vital** funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 2 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. Accident М Investigation within 24 hours after death To the Funeral Director:, completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) TOU

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MARCH 2010 13:56 P. LIONEL WILLIAM MASSEY 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 ☐ F Director 76 JULY 20, 1933 MARYLAND 220-28-2019 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examined must be neithed at 1 □Yes 2 No Directo MARYLAND WORCESTER BISHOPVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12124 BACK CREEK ROAD 21813 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∏Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR CATERING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CATHERINE R. ဂ္ဂ FRANCIS W. MASSEY McTAVISH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12124 BACK CREEK RD., BISHOPVILLE, MD 21813 HELEN G. MASSEY/WIFE Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State CREMATORY OF DELMARVA 3/15/10 DELMAR, DELAWARE 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final tratococcal Physician disease or condition resulting in death) /Medical Due to (or s a consequence o : Examiner s que trally stoodlife if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): 68760 attending pl IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🖪 No 2 1No 1 □Yes Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 1No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only 2 Medical Examiner: nd manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier Swier MO M INA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea W Baier MD 9733 Healthw Healthway Dr Berlin MD 21911

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 3 Day 4:40 PM Clifton Edward Moore, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomi co to50: ce 8. Date of Birth (Month, Day, Sept. 12 9. Birthplace (State or Foreign Country) Virginia Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 1 ⊠ M 2 □ F Months Director 227-40-8177 1929 80 Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Wicomico Salisbury ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6815 Edwards Avenue 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 1954—
If Yes, Give 1956 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ģ 1 Never Married 2 1 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed 1956 Year or Dates. White ا بارک کی میں (1/2 Haltimore, Maryland 21215-15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Terminal Manager Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Moore, Sr. Annie Pauline Northam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Lee Moore- Wife 6815 Edwards Avenue Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 3/13/2010 Delmar, Delaware . Signature of Funeral Service 22. Name and Address of Facility Bounds Funeral Home 705 E Main Street Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOMY OPATHY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specific Spice မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar egistrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 2010 **Physician** 5 5:45a M James Mills /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester 1206 Old Virginia Road Pocomoke If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-12-1943 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** VA 1 **X**M 2 □ F 66 Director 213-44-0570 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10h. County 28a-f show at 1 ☐ Yes 2 X No Examiner must be notified Director MD Worcester Pocomoke 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 6 Items 23a 8379 Bowling Road 21851 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ò 1 ☐ Yes 🏖 No Baltimore, Maryland 21215-0036 Specify: Black ρ 3 ☐ Widowed 4 💆 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farm Laborer Farming 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audrey Belote Golden Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1206 Old Virginia Rd, Pocomoke, MD 21851 Janice Mills/Sister 20b. Place of Disposition (Name of cemetery, crematory or other (13(23)) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □Cremation 3 □Removal from State Mt. Sinai Bapt 3/13/2010 Pocomoke, MD 4 Donation う ☐ Other (Specify) Bennie Smith 917 W. Isabella St 21 Signatur Ineral Service Licensee Salisbury, MD 21801 Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each file. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2□No 1 Yes 2 No 1 ☐ Yes Hospital or Atter ding Physician: After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deaf 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 24 the 29d. Date signed (Month, Day, Year) d title of certifier 29c. License number 29b. Sign

Registrar
DHMH 17 Rev 1/2001

State

Name

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , 2010 Physician Month 21. Chester William Mackereth 8:30 am<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12107 Dandelion Avenue Allegany Cumberland If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Sep 7, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**□M 2□F MD 215-14-6499 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be in affice at 1 ☐Yes 2 ☐ No Director MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12107 Dandelion Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

X1 □ Yes 2 □ No
If Yes, Give
Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chessie Systems Railroad Engineer 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Cora Reed Mackereth Leonard Mackereth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. MD 21502 <u>Sharon Mackereth</u> Daughter Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🖺 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Davis Memorial Cemetery 3/25/2010 MD Cumberland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive 11 01 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Hospital 29a. Certifier 1 🗕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30

Christopher Vagnoni ate filed (Month, Day, Year) 925 Seton Drive Cumberland MD 21502 32 Registrar's Signature

29c. License number

U0059987

29d. Date signed (Month, Day, Year)

3-25-10

Registrar

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			_ For	State of Ma		d / Depa	artment of	Health and	•		•	00701		
	Physici	ian	State Registrar  1. Decedent's Name (First, Middle, L				rtificate of	Death	2. Date of De	Da	ay Year	3. Time of Death		
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- Alexander			CIVISTA MED					LATA			CHAR			
	Funeral Director			Sex 7. Ag 1 □ M 2 ☆ F		ast birthday) 79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JUNE	ay, Year	')   Coi	nplace (State or Foreign untry) H., DC		
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	tems (	uner	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No o Rican, etc.)	)-	14. Race - Amer Black, White	rican Indian,		
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Maryland Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, Itel	ပ	ARTHUR RABA  GOLDIE COX  On Information Name (Raint) Address (Street and Alumbas on Stand Roads Alumbas on Stand R											
	12 m		DAVID MCCOLLE	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Tow  19c. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Tow  7976 OAKWOOD LANE POMFRET, MAR										
Baltimore,	permit. Pages 1 ar Department of Hee Important: If item any Injury or othe once.		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3		20b. Pl		sition (Name of natory or other pla				_ocation - City or T			
Ë	permit. Pag Department Important: any Injury c		4 ☐ Donation 5 ☐ Other (Spec	ify)	MD		CEMETE	and of Facility	2010			M, MARYLAN		
Ba	permi Depar Impor any Ir once.		21. Signardore of Funeral Service Licensee  M00641 5635 WASHINGTON AVE., LA PLATA, M1  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
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	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Cove			from	TTALI	WYLVE	,		+ WEIGH.		
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O. Box	or Attending Physician; The law requires that the death certificate be executed infer death.  Jiffer death.  After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Fetal	death 3	Ectopic pregnan Other (specify)	су			23d. Date of deli Month	very Day Year		
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VII.	/sician s certif lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ant 2□I	ER/Outpatier	t 3 DOA Otl	26. Place of Dea			6 ☐ Other (Spec	26.3		
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	To 1 With To 1 Com	M	29b. Signature and title of certifier	INFA	1	~ · N	29c. Licen	be number	9.	29d. D	ate signed (Month	ı, Day, Year)		
			30. Name and address of person who	completed gause of d	eath (Item	4	Print)	JA,O	on F	n	nd Z	10603		
	Sta Registr		31. Date filed (Month, Day, Year) NAR 30	2010 2010	_		barke							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Miltenberger Donald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND 6 MRM Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Min. 1 🖳 M 2 🗆 F Days Hours (Month, Day Year) 1960 Director 236-08-0852 49 Usual Residence of Decedent 3a or 28a-f show be notified at 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director WV Mineral Ridgeley 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a P.O. Box 606 26753 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced white Completed Year or Dates and 2 should be filed within 72 hour Health and Mental Hygiene. tem 27 is marked other than "natuother traumatic event, the Medical other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Country Club Mall maintanence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Hilda G. (Brown) Miltenberger Jack A. Miltenberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ridgelev WV 26753 19a. Informant's Name/Relationship (Type, Print) father Jack Miltenberger of Health of item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 5 1 Burial 2 Sremation 3 Removal from State 3/18/2010 MD Cresaptown injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Consecution 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pall 1. Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner al Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) been signed by the a should be detached f 9 Unknown P.O. Part II. **Other signific**an<mark>t conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes **Division of Vital** director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes ၉ 1 Xnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier | 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) WILLOWBROOK RD CUMBERLAND MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL HAVAN CHEEMA 12500

DK DH

Registrar

State

31. Date filed (Month, Day, Year)

JOHN JEE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Math Rohrer Norman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Feb. 19,1916 1 □ M 2 😾 F Maryland 214-10-5953 Director 94 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2🌠 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11820 Linbar Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clayton Rohrer Fannie Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward H. Norman, Jr./Son 17827 Lappans Rd., Fairplay, MD 21733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 3/20/2010 4 Donation 5 Other (Specify) Hagerstown, MD Signature of Funeral Service Licensee Rest Haven Funeral Chapel 22. Name and Address of Facility 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine leroseleculi Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signatur d title of certifier Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) educal Campis Rd

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Mo

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MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 **Physician** Month March 14 3:15 PM <u>Verna L</u>innae O'Neill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert 1240 Boyd Rawlings Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 68 Months Days Hours 1941 Maryland 215-38-2736 August Director Usual Residence of Decedent filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Calvert Prince Frederick Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 30 S. Chesapeake Ave. 20678 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Specify: white 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Inc. M. College (1-4or 5+) administrative assistant construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Leslie Gibson Verna Llewella Russell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. O'Neill, Jr. -spouse P.O. Box 754 Prince Frederick, MD 20678 March 188 2010 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Pauls Episcopal Cemetery Prince Frederick Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA BRause 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner (or as consequence of): and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month 5 Other (specify) 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 💃 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 □ No 1 □Yes 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) daughters home Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

24 hours after deat Funeral Director: completely within 2.

State

30. Name and address of person who completed a Jonathan Lowenthal MD dse of death (Item 23a) (Type, Print) 110 Hospital Rd. Suite 310 Prince Frederick MD 20678 31. Date filed (Month, Day, Year) Registra's Signature 2010

🄁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Dav. Year)

Registrar

cal

29a, Certifier

(Check only one)

29b. Signature and title of certifier

10-01947 Christopher L Price	Please Type or Print in Black Indelible Ink. State of Maryland / Department of He		9								
omotopher e i noc	1- For State Certificate of De	ath	2010 09/88 Reg. No.								
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2121 ould be fi d Mental s marked lic event, To Be	Iouis Price  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre	Brenda Carter  SS (Street and Number or Rural Route Nu	mber City or Town State Zin Code)								
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ore, MC s I and 2 sl of Health ar If item 27	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other pla	lame of cemetery, Date	20c. Location - City or Town, State								
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify: Parklawn Mem	. Park 3/20/10	Rockville, MD								
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Mitend Mitend death. ctor: by the f	2 Accident Investigation	1 Yes 2 No									
Division o ospital or Attending hours after death.  Inneral Director: After y filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	or Town,	Street and Number or Rural Route Number, City State) Court, Clinton, MD								
C y fine box	4 V Homicide (Specify) Local Street  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at t										
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred at the time, date	and place, and due to the cause(s)								
3(1)° ×	29b. Signature and title of certifier	9c. License number	29d. Date signed (Month, Day, Year)								
	My a my	O.C.M.E.	March 9, 2010								
	30 Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penr	Street, Baltimore, MD 21201									
State	31 Date filed Michael Con Veerland 22 Pegietrarie Signature										
Registrar	St. Date lied who will be a signature of the state of the										

				Please <sup>*</sup>	Type or Pri							0 0 1 0	09789	
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pr- 14	Medic Examin		4a. Facility Name (if no					4b. City, Tow	n, or Location of De		4c. County of Death			
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9800	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	by	11. Marital Status 1  Never Married 3  Widowed 4	d 2 Married	1 Yes 2 ANo				of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	)-			
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, Maryland 21215-0036	1 and 2 should be file of Health and Mental I i item 27 is marked o cher traumatic eve		19a. Informant's Nam Warren A.				19b. Mailing Address (Street and Number or Rural Route Number, City or Too 5510 Lincoln Ave., Lanham, Maryland							
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Divis	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fune		4  Homicide	determined	28e. Place of Inju building, etc	c. (Specify)				City or To	own, State	)	ral Route Number,	
	le Hosp n 24 hor le Fune bleted fi	Medical	(Check 2	Medical Examin	cian: To the best of er: On the basis of e Practioner: To the	xamination a	and/or invest	tigation, in my c	pinion, death occurr	ed at the time, date	and place	e, and due to the	cause(s) and manner stated.	
	To the within 2 To the comple	_	29b. Signature and tit		hew			29c. Lic	ense number D 4-760		29d. Da	rch 16,2	n, Day, Year)	
>	•		30. Name and addres			•		Print)						
14	Sta	to	Sobhan M 31. Date filed (Month,	athew, M. I Day, Year)	3048 M	itche	llvill	e Road	, Bowie,M	<del>aryland</del>	20	716		
	Sta Registra		MAR 1 7	2010 2	was B.	Ma	Ver .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 14, **Physician** Fausto 2010 4:20 A Paga1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Olney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 09/20/1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 561-54-1402 85 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes XXNo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Maher Court 20744 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1046 11 Marital Status 14. Race - American Indian. 122Yes 2 No 1946-Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Filipino 1 ☐ Yes 2 XXNo þ Specify 3XX Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ire Magnose. Elementary/Secondary (0-12) 12 years College (1-4or 5+) U.S. Navy Military 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Gaudencio Pagal Catalina Mejia ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Maher Court Ft. Washington, Maryland Victor J. Pagal / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 03/31/2010 Maryland Vet. Cemetery Cheltenham, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIAC DISEASE Sequentially list conditions, if a.ry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as aftending use a IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.O. | the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 21 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannes of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0065661 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sterr 1801 Prince Phillip Drive, Olney, Maryland 20832 borah 31. Date filed (Month, Day, Year) MAR 1 7 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month Year **Physician** 8:35 March 16, Stephen Lee PASSARELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington 11030 Clinton Avenue Hagerstown
1 Year | If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7, Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1X M 2 ☐ F 68 Director Feb. 2 1942 Maryland 220-38-0520 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show the Medical Examiner must be notified at 1 Yes 2 No Director 28a-f Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a Funeral 11030 Clinton Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinar 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💟 No If Yes, Give Year or Dates: Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Board of Education Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael F. Passarell Genevieve Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynnette M. Passarell - Wife 11030 Clinton Avenue, Hagerstown, Md. 21740 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 3/18/10 Hagerstown, Maryland 21. Signature of Euneral Service Licenses 22 Name and Address of Facility Minnich Funeral Home 4/15 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Pall Finter the disease, or complications that crused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chyonic disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2□No P.O. 9 Unknown ed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**(Vo 1 ☐Yes 2 ☐ No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No al Director: A investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3H-5

State Begistrar

To the Hospital within 24 hours a To the Funeral C completely filled

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

That one was seen 124 006

TSacrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

-18-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Parrish 2010 March 02:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 01ney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Disconting (Month, Day) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months New York Director 172-18-2221 89 Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Md. Montgomery Silver Spring 1 Yes 2 No 10f. Zip Code 10e Street and Number ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20906 13130 Valleywood Drive United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic ever" (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Berkebile Stanley Mills Goldie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Parrish, Jr. / Son 15890 Union Chapel Road, Woodbine, Md. 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 3/14/10 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Sa Box 5038, Laytonsville, 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Perforated Viscous disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed Cartoid Artery Stenosis that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death ned by the a 1 Yes 2 E Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 2 🗹 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number March 12, 2010 D 25947 30. Name and address of sop who completed cause of death (Item 23a) (Type, Print) Evelyn Jackson, M.D. 3416 Olandwood Court, Suite 200, Olney, Md. 20832 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Padgett Dorothy May Physician/ March 122 2010 12:42A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charles **Examiner** LaP1ata Charles Co. Nurs. and Rehab Ctr. 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX Hours Days Min. Oct 31. 1926 Washington DC **Director** 578 30 0128 83 Usual Residence of Deceden E If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Charles Waldorf Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20603 2305 Watertrumpet Court United States filed within 72 hours after death val Hygiene.

Jother than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXX No Specify. White Specify: 3 
▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Melito Mary Irene Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Watertrumpet Court, Waldorf, MD 20603 Debra L. Craig, (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d S mat for of Funeral privide Licenses Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Pirector After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

122

Fatima Hussein, M.D.

MAR 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

5625 Allentown Road, #101, Camp Springs, MD 20746

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mar OXIE Purnell 10 2010 /Medical 4b. City, Town, or Berlin 4a. Facility Name (If not institution, give street and number, Town, or Location of Death 4c. County of Death Examiner Worcester Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Year 1 □ M 2 □ F Months Days Hours Min 219-34-2982 Director laryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho Maryland Berlin 1 Pres 2 □ No Funeral Director death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of america 10818 Maple 21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 9/16/37 DOD: 3/11/10 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Black ş 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. 3m 27 is marked other than "the traumatic event, If a Mer Elementary/Secondary (0-12) College (1-4or 5+) aborer 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Albert ပ Ohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Belationship permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trat Berlin NIECE 8846 ewis Kd Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)
St. Poul Cemetary Date 20c. Location - City or Town, State 1, Burial 2 Cremation Berlin, Maryland 3 ☐ Removal from State Mar 18, 2010 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee Harris-Wock Funeral Sorvice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OPD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highry that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) to the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/12/2010 D0064120 2 mil and address of person who completed cause of death (Item 23a) (Type, Print Berlin AGH 9733 Health way Drive Atif Zeeshan 31. Date filed (Month, Day, Year) MAR 16 Registrar's Signat State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Fordham Poffen		1- For State	f Maryland /	Department o Certificate o		nd Mental	-	Reg. No.	0 00100
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)					2. Date of De		3. Time of Death
Medical Exami	ner	Fordham Lee Pof 4a. Facility Name (if not institution, give s	fenbarge	r			March 2	1, 2010	0420 hrs
	:	4a. Facility Name (if not institution, give s University Hospital	treet and number)		4b. City, Town, o Baltimore	or Location of De	ath	4c. County of	Death
Funeral		5. Social Security Number 6. Sex	7. Age (	(In yrs, last birthday)	If Under 1 Ye	ear If Under 24	Hrs. 8 Date of 6	Birth (MM/DD/YYYY)	9. Birthplace (State or
Director		213-73-3334 1K N			Months Da		Alia.		Foreign Country) MD
		Usual Residence of Decedent	2 7	· • • • • • • • • • • • • • • • • • • •	S.		0/2/	2007	TID
any	- 1	10a. State 10b. County	11	0c. City, Town or Loca	tion				10d. Inside City Limits
and show	占	MD Freder	ick	ľi	iddlet	own			1 Yes 2 No
Maryli 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Flygene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.		6776 Burkittsv	ille Rd.		21	1769		US	5A
th wit cens 2	Funeral	11. Marital Status  1 X Never Married 2 Married	<ol><li>Was Decedent Ended Forces?</li></ol>		as Decedent of H res, specify Cuba		Specify Yes or Norto Rican, etc.)	No- 14. Race - A White, e	American Indian, Black, etc.
er dea	큔		1 Yes 2 X Yes, Give Year	No 1	Yes 2X N	lo specify:		Specify:	White
ırs aft tural" ımine	ģ	15. Decedent's Education (Specify only	r Dates:	leted) 16a. Deceder	nt's Usual Occup		of work done	16b. Kind of Busin	
72 hou	eted	Elementary/Secondary (0-12)	College (1-4 or 5+	during n	nost of working lif	fe. DO NOT use	retired)		
5-0036 lled within 7 Hygiene. I other than	omple	0		no	ne			no	ne
15-0 filed v Hygi d other,	ပ္တို	17. Father's Name (First, Middle, Last) William H. Pof	fanharaa	r Ir			me (First, Middle	, Maiden Sumame)	
2121 Muld be fi Mental I marked	9 Be				a Address (Stee				State 7in Code
ID 2 shou and N 77 is n	의	19a. Informant's Name/Relationship (Typ William Poffenb	arger Jr	(Father	)6776	Burkit	sville	Rd., Mi	ddletown, MI
and 2 and 2 fealth		20a. Method of Disposition		20b. Place of Dispos	sition (Name of c		Date	20c. Location - C	
MOFe, Pages 1 at tent of He aut: If ite		1 X Burial 2 Cremation 3	Removal from State	rematory or of Reforme	<sub>her place)</sub> d Ceme 1	terv 3	/25/201	dMiddlet	own, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death will Department of Health and Mental Rygene. Important: If them 27 is marked other than "natural", or items? injury or other traumatic event, the Medical Examiner must be a	1	Donation 5 Other Specify: 2 Fignature of Juneral Service License						uneral E	
Depring Deri		/ hutch / Mor	TOL		OB 18.	Middle	ipson r town.	MD 21769	)
Physician	7	23a. Part/I. Enter the disease, or complic failure. List only one cause on each		e death. Do not enter t	he mode of dying	g, such as cardia	c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/M dical Examiner	11	Immediate Cause (Final disease a.	wning with co	mplications					Death
		or condition resulting in death)	e to (or as a consequ	uence of):					
	ē		e to (or as a conseq	uence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		- 0				_	
ecuted and transit		events resulting in death) Last Du	e to (or as a consequ	dence or).					
×	edical	UNPENDED	AMENDED						-
Sox 68760, leath certificate be en e attending physiciar for use as the burial	Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	livery
Box 6876 e death certificate the attending phy ed for use as the U	ian/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth		etal death 3	Ectopic pre	gnancy	Month	Day Year
Sox 6 leath cer e attendi for use	/sici	1 Yes 2 No 9 Unknown	Pregnant at tin	ne of death 5 O	her (Specify)				
O. B. at the de by the ached f	Phy	Part II. Other significant conditions co	ontributing to death b	out not resulting in the	underlying cause	given in Part I.	23e, Did	tobacco use contribu	te to the cause of death?
i, P.O.	d by						_ 1 _ Y	es 2 No 3	Probably 4 V Unknown
cords law requi has been a	Completed						24a. Wa		re autopsy findings available or to completion of cause of
eco he law te has	틹			·			perl	formed? dea	th? Yes 2 No
tal Rec	BeC	25. Was case referred to medical			- 26.Plac	ce of Death (Che			
Division of Vital Records, rat or Attending Physician: The law requints after death.  **I Director: After this certificate has been siled in by the funeral director, page 2 should it	o١	examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient	2 🗸 ER/Outpatient	3 DOA	Other <sub>4</sub> Nur	sing Home 5	Residence 6	Other:
n of V ding Ph	i.i	27. Manner of Death  1 Natural 5 Death	28a. Date of Injury (Month, Day Year Mar 20, 2010			ury at Work?		how injury occurred	ain vehicle overturned
sior ttend death. ctor:	ä	2 Accident 5 Pending Investigation				Yes 2 V No	in stream		
Divis pital or At ours after d teral Direc	ertification:	3 Suicide 6 Could not be determined		y - At home, farm, stre	et, factory, office	building, etc.	or Town,	State)	or Rural Route Number, City
ospita hours uneral	ပ	29a. Certifier	(Specify) Cree			data and alass.		sville Road, Middle	
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Examiner: 0	n the basis of examin	nowledge, death occu nation and/or investiga					
To viit	Š	29b. Signature and title of certifier	nd manner stated.		29c. Licen	ise number		29d. Date signed	(Month, Day, Year)
		The MI	1. 70	1	O.C	.M.E.	OCME	March 22, 20	10
	ŀ	30. Name and address of person who cor	npleted ause of dea	ith (Item 23a)			111		
		Theodore M. King, Jr., MD.		dical Examiner	111 Penn S	treet, Baltim	ore, MD 2120	)1	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	91. P.S				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12:15 am March 12, 2010 Gerald Proger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olney Montgomery Montgomery General Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1**⊠** M 2□ F 057-22-6386 80 New York 03/16/1929 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mychon Evantimer must be notified at 1 ☐ Yes 2 🛛 No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2901 S. Leisure World Blvd., #302 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XIYes 2 No Korean
If Yes, Give Korean
Year or Dates: Conflict 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No Specify. þ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CPA/Lawyer Accounting/Law 5+ 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Tashlitsky Benny Pogrebinsky 19a. Informant's Name/Relationship (Type. Print) Sylvia Proger - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 💹 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gdrns 03/14/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Hunera Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one caus An each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS **Physician** resulting in death) /Medical (or & a consequed of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physiciar Completed by Physician/Medical as the IF FEMALE: use 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy for Month Day Year 5 Other (specify) detached □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 00941 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

29b. Signature and title of certifier

Padmaja Bandi, MD, 31. Date filed (Month, Day, Year) MAR 16 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

18101 Prince Philip Drive, Olney, Maryland 20832

29c. License number

D0068026

29d. Date signed (Month, Day, Year)

10

Year

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

3250 Starting Gate Ct. Woodbine, Md 21797

Ellen R.Farrell CRNP

31. Date filed (Month, Day, Year)

MAR 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March14 pay 2010 Physician/ Dina Antonia Sarmiento Rodriguez 7:25a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Hours none Months ма<sup>му</sup>4, <sup>Д</sup>ү 962 Peru Director 47 Jsual Residence of Decedent show 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified MD Rockville Montgomery 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 312 Mount Vernon Place 20852 Peru 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes : 2 🔀 No Maryland 21215-0036 ¹\XYes 2□No Specify: Peruvian Specify: White "natural" Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Glive kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPET (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Balbina Rodriguez Castillo Sergio Sarmiento Condori 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14010 Shippers Lane Rockville, Md. 20853 Luis Criollo/Friend Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other p Jardines Del Buen Retiro X Burial 2 Cremation Removal from State ☐ Cremation L**X**F 5 ☐ Other (**%pecify**) 3/22/2010 4 Donation Lima, Peru 21. Signature PHILIP OF RIWALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring,Md20910 9241 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Multiple Myeloma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam as the burial-transi that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year Yes 2 No Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? 1 Ves 2 No this certificate Yes 2 No Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After Hospital or Attending 1 Natural 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🙋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Funer completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Fractioner: To the best of my knowledge, death uco diet the fine, date and plane, and due to the nauso(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51616 March 14,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nelson Kalil M.D. 5454 Wisconsin Ave #1300 Chevy Chase, Md20815 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAR 16

2010

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32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav 5:00 a M March 11, 2010 Charles Edward Randall, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert 1785 Horace Ward Road **Owings** If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 **⊠** M 2 □ F MD July 24, 1922 218-12-9451 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2XNo **Owings** MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20736 USA 1785 Horace Ward Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 🗷 No Specify. Specify: 3 ₩ Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Chauffer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susie Randall Charles Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1785 Horace Ward Road, Owings, MD 20736 Michael Randall Sr. - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) March 19, 2010 Owings, MD Wards Mem. UMC 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. Glady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) or as a consequence of omorea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe Yes 2 1 ☐ Yes

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

**Director** 

show

Director

Funeral

ģ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f st any injury or other traumatic event, the Madical Exempter must be notified.

Maryland 21215-0036

/Medical

be executed and burialattending physician the as Ś has

Box 68760,

P.0.

Records,

**Division of Vital** 

page 2 should certificate funeral After t death. 24 hours after death Funeral Director: the

Certification: To

Hospital or Attending Physician: completely filled in by within 2. 5+1 State Registrar

Examiner Physician/Medical \$ Completed Be

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

5 ☐ Pending investigation 6 ☐ Could not be

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2417 32. Registra & Signature

29d. Date signed (Month. Dav. Year)

Solomon Island Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death STANLEY Physician/ OWCAND Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 10-31-1951 Mary Land **Director** 58 217-56-3164 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20776 USA 4338 Solomons Island Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) self employed carpenter-contractor construction injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Arthur Martin Rowland Ivv1 Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Rowland Pearce, daughter 5865 Governor's Hill Drive, Alexandria, VA 22310 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 3-13-2010 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year signed by the a 1 Yes 2 9 Unknown 2 🗌 No Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 2. No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c, Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 110/452 Natural Accident injury 5 Pending Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie Date signed (Month, Day, Year) 0 Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEYENSE HIGHWAY A

DRW 8 State

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

NNAPOLIS MOLIYUI

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar		State o	it Mai	ryland /		rtment of F tificate of I	lealth and N D <i>eath</i>	vientai F			0	09801	
	Physicia		1. Decedent's Name (First, I GERALDINE RA		*						2. Date of Month March		Day Y	/ear	3. Time of Death 8:43 P M	
1	/Medic Examin		4a. Facility Name (If not inst			mber)	····		4b. City, Town, or	Location of Death			4c. County of			
d.			St Thomas Mo			7 4	(la some to at h	a i mate 1	Hyattsv If Under 1 Year	ille If Under 24 Hrs.	9 Date of	Dieth	Prince		•	
ı	Funeral Director		5. Social Security Number 498–32–0237		ex □M2K2F	7. Age	(In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of (Month, May 28	Day, Y	ear) 1932 L	ittl	place (State or Foreign Intry) e Rock, AK	
	/land		Usual Residence of Deceder 10a. State 10b. Co.				10c. City, To	wn or Loc	ation						10d. Inside City Limits	
	a-fsh	ctor	DC			,	Washin	gton							1y∑ Yes 2 □ No	
	or 28	Director	10e. Street and Number			•			10f. Zip Code	22211		10g	. Citizen of Wh	at Cou	ntry?	
	eath w	Funeral	610 Ingraham	Stree	12. Was Dec	edont Ev	or in 11 S	12 \	Vas Decedent of H	20011	necify Ves or	No	USA	Δmer	ican Indian,	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maryland Eventies must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ 3 1 Widowed 4 □ Divo		Armed For 1 Tes. If Yes, Giver or D	orces? 2 <b>X</b> No ive			Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	NO-		White,	, etc.	
ח	72 hc "natur	Completed	15. Dec (Specify only I	edent's Edu	ucation de completed)		16	a. Deced (Give I	ent's Usual Occup	ation during most of work f)	king	16	b. Kind of Busi	ness/Ir	ndustry	
7	filed within Hygiene. wher than "	duc	Elementary/Secondary (0- 12th	12)	College (	1-4or 5+	) E		tive Ass				Priva	te		
2	other	Be C	17. Father's Name (First, Mi	ddle, Last)						18. Mother's Nam	ne (First, Mide	dle, Ma	iden Surname)	,		
7	should be and Mental s marked c umatic eve	70 E	Charles R	ainey						Hatti	ie Re	eid				
0	2 shc h and r is m raum		19a. Informant's Name/Rela							and Number or Ru						
ני	1 and Healt tem 2		Chery1 D. Fe	IIS -	Daugni	cer			sition (Name of patory or other place	d Court, N	Date		c. Location - C			
Dallillo	t. Page rtment c rtant: If rjury or		1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	er (Specify	')	State		ny M	em. Pk.	3/12			ndover			
מם	permi Depar Impor any Ir	(_ ) <sup>(</sup>	21. Signature of Funeral Se	20-	11	en	K	71	6 Kenned	y Street,	, NW, V	Vast	nington		eral Home C 20011	
			23a. Part1. Enter the disease shock, or heart failure	e, or comp List only o	cations that one cause on o	caused t each line	he death. D	o not ente	er the mode of dyir	ng, such as cardiac	or respirator	y arres	t,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a				E CANCER					1		
	Examiner						consequenc									
	B +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		U		consequent									
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		C	(01.00.0	consequenc	a of):								
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00	ertifica ing ph e as th	Medi	IF FEMALE:	1.5	7. F									1		
O. DO.	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ysician/M	23b. Was decedent pregnatin the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	11.		birth 2 gnant at t	f pregnancy ☑ Fetal dea time of death		Ectopic pregnanc Other (s <i>pecify)</i> _	у					23d. Date of delivery Month Day Year	
Ž.	s that ined by	by Phy	Part II. Other significant co	nditions or	ontributing to c	leath but	not resulting	j in the un	derlying cause giv	en in Part I.	23e. D	id toba	cco use contrib	oute to	the cause of death?	
SDIOS	equire en sig ould b										1	☐ Yes	2 <b>X</b> No 3	Pro	obably 4 🗌 Unknown	
משבו וג	: The law requires that the decate has been signed by the page 2 should be detached	Completed									24a. W at pe 1 □ Ye	utopsy erforme	ed? pri	ior to c	topsy findings available completion of cause of 2 □ No	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sician certifi irector	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 🔼 No	i i	Hospital:	1		0. 4. 4. 4.	Oth	26. Place of Dea			0 F0#		***	
5 = 5	ding Physician; The In. After this certificate ha funeral director, page	ication: To	27. Manner of Death 1 ☑ Natural 5 ☐ P	ending	28a. Date (Mor		t 2 ☐ ER/0 / /ear) 28b	o. Time of Injury	28c. Injur	y at			ce 6 Other		ury)	
	To the Hospital or Attending Physician; within 42 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p.	Certificat	3 ☐ Suicide 6 ☐ C	vestigation ould not be etermined	28e. Place	e of Injur ling, etc.	ry - At home, (Specify)	farm, stre	eet, factory, office	res 2 🗆 110	28f. Locatio City or	n (Stre Town,	et and Number State)	r or Ru	ral Route Number,	
	Hospita 24 hours Funeral etely filler	edical C	29a. Certifier 1 Cer (Check only one) 1 Me	tifying Phy dical Exam	ysician: To the liner: On the land mar	basis of	examination	dge, death and/or inv	occurred at the tivestigation, in my o	me, date and place opinion, death occu	e, and due to irred at the tir	the cau	use(s) and mar e and place, ar	ner as	stated. to the cause(s)	
	To the within To the Compl	Me	29b. Signature and title of co	hifier	(	. 4 4	^		29c. Licens	e number		290	d. Date signed	(Month	ı, Day, Year)	
			Hay 1	Mu	un,	M	1)1		D002	1955			3/10	1	0	
2	15		30. Name and address of pe							verdale,	Mary1	and	20737			
	Sta Registr		31. Date filed (Month, Day, MAR 1 6 20		22. 1 Energy											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Ruby Entzminger Smith Month Day Physician/ 2:45p M 2010 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Nursing Ctr Fox Chase Rehabilitation & Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7, Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2**X** F Days Hours Min (Month, Day, Year) 579-30-0377 96 Yrs South Carolina Director 9. 1914 Feb. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director DC N/A Washington 1XXYes 2 ☐ No 10f. Zip Code **2001**2 10e. Street and Number 10g. Citizen of What Country? Funeral Street, NW 1913 Tulip United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Was Decedon... Armed Forces? ¹ ☐ Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after African 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced A merican the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Suber ည Hattie Thomas Jefferson Entzminger 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: if item 27 is 1 any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Street, NW, Washington DC 20012 Della Mae E. Burke /niece 1913 Tulip 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland Lincoln Memorial Cem: 3/12/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW, Washington DC 20012 Tho 22 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Dementia Sequentially list conditions, Examine Due to (or as a son sequence or). it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Coronary Artery Disease that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Peripheral Vascular Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2**XX**No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes 2 x No 25. Was case referred to medica 26. Place of Death (Check only one) Be 2**X** No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4xxNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1XXNatural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ARLENE -40AM Haz J 2010 /Medical Facility Name (If not institution, give street and Town, or Location of Death 4c. County of Death Examiner HOWF and Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex . Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X 73 Director 072-28-7998 09/24/1936 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar must be restilled at 1 ☐ Yes 2 No Director Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10777 McGregor Drive 21044 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Caucasian Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Suchoff Shirley Sucher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Columbia, Maryland 21044 Joseph Stirmer - Husband 10777 McGregor Drive. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns: 03/14/2010 Olney. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Min 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner eri The law requires that the death certificate be execresulting in death) Last Due to (or as a consequence of) burial-Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 month Month Year Day 5 Other (specify) P.0. ed by the a 9 Unknown 9 ☐ Unknow signed h 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autops) perform certificate 2 No 1 ☐ Yes 2 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural
Accident 5 Pending death. n 24 hours after death.

le Funeral Director: A pletely filled in by the fu 1 ∏Yes 2 ∏No investigation Location (Street and Number or Rural Route Number, City or Town, State) ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. \$ignature and title of certifier ٩

State Registrar

DHMH 17 Rev 1/2001

RD COUNTY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

(Month, Day,

Year)

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ March 14 Consolacion Arlante Sayson 8:40PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 5507 Sachem Drive Forest Heights Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕏 F Months Days Hours March 2<sup>ay,</sup> 1942 Philippines 548-73-7390 Director Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Prince George's Forest Heights XXXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5507 Sachem Drive 20745 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 5 1 Never Married 2 Married 1 Yes If Yes, Give 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Filipino "natural" 3 Widowed 4 K Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 4 years Babysitter Child Care other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill treet of Health and Mental tant: If item 27 is marked o 2 Julian Arlante **Fulgueras** Luisa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Sachem Drive Forest Heights, Maryland Andrew Sayson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 Burial 2 Cremation 3 TRemoval from State 03/24/2010 Important: If any injury or once, Manila Memorial Park Manila, Philippines 4 ☐ Donatiop 5 ☐ Other (Specify) 21. Signature f Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final HE Physician disease or condition Medical resulting in death) Due to ras a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 🗷 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Dending work Investigation 6 Could not be 1 Yes 2 No Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of dea th (Item 23a) (Type; Print) ST. N.W. WAShINGTON DC 20010

Registrar

State

MAR 1 7 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signatu

1 - State Registra

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

Joan Elaine Schleutermann

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 1715 Coster Road Lusby Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Min. 1 □ M 2 🖼 F Months Days Hours 74 09/29/1935 Maryland Director 216-32-8845 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show traumatic event, the Medical Examinant must be notified at 1 ☐ Yes 2 No Director Lusby Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1715 Coster Road 20657 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∰No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 H Married "natural", or 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Nursing Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Barrett George Raymond Abell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. Walter M. Schleutermann/Spouse 1715 Coster Road, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 03/19/2010 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UMC Cemetery Lusby, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signatore of Funeral Service Licenses Thickard Klern, P.O. Box 600, Lusby, MD 20657 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise se, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Demen 7 /Medical Due to (or as a consequence of): **Examiner** NIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? vas 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No reral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D234668 March 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road, Suite 303, Prince Frederick, MD 20678 Mark J. Kushner, MD, 31. Date filed (Month, Day, 32. Registrar Signature State 1010**>** acked Ceneur Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. /

3. 2<u>010</u>

9:30

РМ

2. Date of Death

March 13,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 20<u>10</u> March March Physician/ Franklin Delano Sievert 12  $P^{M}$ 8:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 01/30/1934<sup>ar)</sup> 214-30-2136 Director 76 Germany Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 The No Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ₺ Yes 2 □ No If Yes, Give 1956—58 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: White res, Give Year or Dates, 1956–58 3 Widowed 4 Divorced Specify: "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Earnest Sievert Mary Christena Gerstner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis A. Sievert / Son P.O. Box 1182, Lusby, Maryland 20657 / arepsilonBaltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 B Cremation 3 Removal from State 03/13/2010 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility . Signature of Funeral Service Licensee Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the diseas, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 046 Medical resulting in death) Due to (or as a consequence of): Examiner 4070 Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? JYes 2 □ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown ive Cebullan Digesso 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After I Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрые 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) and title Acertifie 29b. Signato ress of person who completed cause of death (Item 23a) (Type, Print) Stephen P. Cafferty, 22333 Greenview Pkwy, Unit 5A, Great Mills, MD 20634 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 15 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 09807 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 15<sup>Day</sup> **Physician** 2010 Mary C. Snyder 1:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Months Days Hours Min. 1 □ M 2 □XF 871871943 217-44-5341 66 washington D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County **Funeral Director** 1 ☐Yes 2 ☐No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Beaconhill Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married If Yes, Give Year or Dates: ģ 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounts Payable NIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles O. Green Catherine Judge ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Snyder, Jr. /husband 49 Beaconhill Rd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 3/19/2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse unice of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and things in death to the cause of the caus Due to (or as a consequence or). Physician/Medical Examiner resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the Underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Miknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

**Funeral** 

**Director** 

ms 23a or 28a-f show

items

permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, If a Madical Evantines once.

Baltimore, Maryland 21215-0036

death with the Maryland

certificate has been signed by the ettending physician and rector, page 2 should be detached for use as the burial-transit

SS# 211-44-534

Division of Vital Records, P.O. Box 68760,

Completed by funeral director, Be ation: To After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aff

27. Manne of Death 1 Natural

DN 10

Certific	3 □ Suicide 4 □ Homicide
edical	29a. Certifier (Check only one)
ž	29b. Signature ar

1 ☐ Yes

2 Accident

31. Date filed (Month

2 HO

State Registrar

ignature and title of cer

determined

5 Pending

investigation 6 ☐Could not be

1 patient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Math, Day, Year) 29c. License number

Mame and addr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Blanche Isabelle Somerville 03/10/2010 5;30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent 11167 Oak Lane Worton 8. Date of Birth (Month, Day, Year) 07/15/1907 Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 T F 102 Director 216-14-9467 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, It a Madical Examinar must be notified at Worton 1K Yes 2 □ No Director Kent MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11167 Oak Lane 21678 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Vista Foods Laborer 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ပ Rev. Albert Walker Cora Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11167 Oak Lane Worton, MD 21678 Phyllis Somerville (daughter) 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 of . Burial 2 ☐ Cremation 3 ☐ Removal from State 03/16/2010 Chestertown, 4 ☐ Donation 5 ☐ Other (Specify) Olive 22. Name and Address of Facility 21. Signature of Funeral Service Licensee omme Bennie Smith FH Route 298 Worton, MD 21678 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** helenones disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown cate has been signed page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 - No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Box 68760 Ö σ. Records, Division of Vital Attending Physician: funeral After

death. filled in by

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

Medical Certification: To

D

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes

2 No

00060301

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause leath (Item 23a) (Type, P For A) 5725 COPESTERIOUR, NO

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated

2 No

5 Pending

tle of certifie

investigation

6 Could not be determined

1 Yes

27. Manner of Death

2 Accident

4 Homicide

(Check only one)

29b. Signature a

3 Suicide

1 Natural

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 Charles E. Steward, Jr. 20°10 0349 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis
If Under 1 Year I If Under 24 Hrs. 6. Sex. 1 A M 2 A F Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 2 100 1 1 0 ay, 1 2 3 8 MD ntry) **Director** 218-34-9641 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Somerset Crisfield 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Locust Street 21817 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status was Decedent Ever in U.S. Armed Forces?

¼☐ Yes 2 ☐ No 55-58

If Yes, Give Year or Dates. Army 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) and Mental Hygiene. is marked other than Filing Cabinet Elementary/Seconday (0-12) College (1-4 or 5+) Spot Welder Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Charles E. Hall Ollie Mae Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11749 19a. Informant's Name/Relationship (Type, Print) Kimberly Johnson/Daughter 176 SunFlower Lane. <u>Islandia,</u> New York Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Veteran's Cem 3-17-2010 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury, MD 2180 Funeral Home Salisbury, MD 2180 Signature of Euperal Service Licensee Salisbury, MD 21801 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Exam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 9 Unknown signed by the a be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XÑo မ 1 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 114 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurre Practioner T. The cost of my income death occurred at the time, date and place and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tip e of certifier

3m

31. Date filed (Mor State Registrar

30. Name and address

Olexo registrar's Signatur

ed cause of death (Item 23a) (Type, Print)

29c. License number

1258510

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201<sup>Year</sup> Month Day **Physician** 25, Mar. 6:50 AM L. Gloria Shaffer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Freeland Baltimore 1912 Bulls Saw Mill Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 30, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□ M 2 🖁 F Days Hours Months June Yrs. PA 80 Director 207-22-0675 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County "natural", or items 23a or 28a-f shov 1 Yes 2 No Director Baltimore Freeland MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1912 Bulls Saw Mill Road 21.053 U.S.A. death 1 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ₩Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, It's Madical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Public Schools 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Arthur King Clara Elmira Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other training once. G. Diane Morfoot/Daughter 993 Anthony Rd. East Berlin, PA 17316 20b. Place of Disposition (Name of compton), crematory or other place)
Pine Grove U•M•
Cemetery Mar. 30, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkton, MD 2010 `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Juneral Service Licens 24 N. Second St., New Freedom, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensine Cardio Vascular Diaesse Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of): **Examiner** 6 mential Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as d consequence of) Examiner certificate be executed the burial-transi Due to (or as a consequence of): nding physician Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an autopsy performed' 2[17 No 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann t Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Minth, Day, Year) 29c. License number 29b. Signature and title of pertifier pleted cause of death (Item 23a) (Type, Print) MD , 16921 York Road Monkton, MD 21111 KAPLAN

DX.

DHMH 17 Rev 1/2001

State

Registrar

Carl.

32. Registrar's Signature

24 W

DHMH 17 Rev 1/2001

State

Registrar

me and addr

Beverly Calkins M.D ate filed (Month, Day, Year)

MAR 30

Parke

500 Memorial Ave Ste 105 Cumberland MD 21502

of person who completed cause of death (Item 23a) (Type, Pmt)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 2010 09812 Thomas Edward Sturgill

		1- For State Registrar		Ce	rtific	ate of	Death				Reg	g. No.			
Physiciai Medical Examin	n/ ier	Decedent's Name (First, Midd     THOMAS	EDW		S	TURG	ILL				Date of Death	n Day Yea	ar	3. Time of Death 0830 hrs	
		4a. Facility Name (if not institution 2025 Trappe Church		imber)					ocation of De	ath		4c. County Harford	of Death	1	
Funeral Director	- 1	5. Social Security Number 219–42–0144		7. Age (In yrs.		hday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	. Date of Birth		Foreig	thplace (State or in <sup>untry</sup> laryland	
w any	ŀ	Usual Residence of Decedent 10a. State 10b. County				or Locatio	on				10/4/	1944		10d. Inside City Limits	
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	arford				De 10f. Zip C		ngtor	1		g. Citizen of Wh			
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Funeral D	2025 Trapp  11. Marital Status  1 Never Married 2 M	12. Was Dec	s Decedent Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic					Origin? ( Specify Yes or No- 14			ited States  14. Race - American Indian, Black, White, etc.			
ours after de itural", or aminer mi	≥ -	3 Widowed 4 Div	orced If Yes, Give Yea or Dates:		16a. l	Decedent'		cupation	(Give kind		done	Specify:		/hite	
5-0036 led within 72 hours Hygiene cother than "natur the Medical Exam	Completed	Elementary/Secondary (0-12)	C	College (1-4 or 5+)			st of workir Witc	hma		,				unications	
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene in 27 is marked other than an amatic oven, the Medisa	<u>&amp;</u>	17. Father's Name (First, Middle,	Carlton	S = 12 = =	Stu	rgil	1	K	athar	rine	e E	aiden Surname lizabe	th	Pyle	
O 8 5 2 5 1		19a. Informant's Name/Relations  Katharine E.  20a. Method of Disposition		1	1:	16 W		rre	ttsvi	lll (	e Rd.		st	Hill, MD.	
Baltimore, ME permit Pages I and 2 s Department of Health a Important: If item 27 injury or other trauma		1 Burial 2 Cremation 4 Donation 5 Other Sp 21 Signature of Fungral Service	pecify:	om State	cremate	ory or othe	er place)	tio	Ma	1000	n 29,	Uamna	+ 0 0	A MT	
Physician		23a. Part I. Enter the disease, or	n Kurs complications that pa	used the death	. Do no	НО	me,	P.A		Jari	retts	ville.	Ma	Funeral ryland Approximate Interval	
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Contact Gu  Due to (or as a			lead								Between Onset and Death	
	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	consequence o	f):										
	EX	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	f):										
8760, tificate be executed ng physician and as the burial - transit	Medic	UNPENDED  F FEMALE: 3b. Was decedent pregnant in the		outcome of preg								23d. Date of	,		
<b>∞</b> ⊕ ≅ ≅ 1 1	<u>a</u>	past 12 months?	I L Live Di	rth ant at time of de wn	ath 5		l death er <i>(Specify</i>		Ectopic preg	nancy		Month	D	ay Year	
P.C es that igned	6	Part II. Other significant conditi	ons contributing to	death but not re	esulting	in the und	derlying ca	use give	n in Part I.					he cause of death? ably 4 Unknown	
of Vital Records, ge Physician: The law requinter this certificate has been simeal director, page 2 should be a feed of the Complete of the Co	Сошріетей									- [	24a. Was an autopsy perform	ed? de		opsy findings available ompletion of cause of	
tal Rections: The certificate ector, page	20 J	25. Was case referred to medical			_		26.1	Place of	Death (Chec	ck only o			V Tes	2 110	
Viti	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 1	patient 2	ER/Ou	tpatient	3 DOA	Oth	er <sub>4</sub> Nurs	sing Ho	me 5 Re	esidence 6	Other:	Scene	
tending Ph death. ttor: After t y the funeral	ation:	27. Manner of Death  1 Natural 5 Pend 2 Accident Inves	ing 28a. Date of FOUND: Mar 23, 2	Day, Year)	28b. T FOUI 0815		1	. Injury a	t Work? 2 ✓ No		Describe how ject shot s	w injury occurre self	ed		
Division o  To the Hospital or Attending Whith 24 hours after death. To the Funeral Director: After completely filled in by the fune		4 Homicide determination	not be	of Injury - At ho Single Fam				fice build	ling, etc.	1	or Town, Stat			al Route Number, City ton, MD	
To the Ho within 24   To the Fu completely	ed Car		ysician: To the best niner: On the basis o and manner st	f examination a			n, in my op		ath occurred		time, date an	d place, and du	e to the	cause(s)	
		Tide Valle	Gleden	2050	00.			Cense no			126	29d. Date signe March 24, 2		n, ∪ay, Year)	
		30. Name and address of person Victor Weedn MD JD	who completed cause Assistant Med		•	111 Pe	nn Stree	et, Balt	imore, MI	D 212	01				
Stat Registra	~	31. Date filed (Month, Day, Year)	32. Reg	gister's Signatu	re	. 6	guilla	Ø							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ MARCH 14, 2010 7:25 Ам GERALDINE LEE THOMPSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RISING SUN CECIL HILL TOP MANOR If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Davs Hours Min. 4/26/192 ALABAMA Director 88 220-22-01<u>41</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sh notified a RISING SUN CECIL MD 1 🗌 Yes 2 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 21911 UNITED STATES 1728 JOSEPH BIGGS MEMORIAL HIGHWAY death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc 1 ☐ Yes 2 🗓 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER EDUCATION Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ DEXTER C. LEE MARGARET RIDDLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH L. THOMPSON/SON 707 ELKTON BLVD ELKTON, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pla DELAWARE VETERANS MEMORIAL CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🛣 Burial 2 🗌 Cremation 3 ី Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/18/2010 BEAR, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SPICER-MULLIKIN FH NEW\_CASTLE. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Pregnant at time of death ned by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be o 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. hd title of certific ame and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician March .010 Juanita Virginia Thomas /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Laurel Regional Hospital George's \_aure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2**X** F Months Hours Min **Director** 233-50-1182 79 01-08-1931 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State ir than "natural", or items 23a or 28a-f show the Medical Exprimer must be notified at 1 ☑ Yes 2 ☐ No Directo P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 5705 Jost Street, U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Black ģ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mydie once. Elementary/Secondary (0-12) College (1-4or 5+) Nutritionist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Broadnax Ralph Franklin Louise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kim Brooks-Marshall - Daughter 5705 Jost Street, Capitol Heights, Maryland 20743 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery: 03-20-2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home Konsi 108 W. North Avenue, Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** hour /Medical Due to (or as a consequence of): Examiner Cardiovascular Disease teriosclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine iabetes Mellitus attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Year Month 5 Other (specify) ed by the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ erebrovascular Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy certificate ha 1 □ Yes 1 ∐Yes 2 No After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2**X**No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 124 hours after death.

le Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

within 2.

State Registrar

29a. Certifier

(Check only one)

Medical

29b. Signature and title of certifier

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my onicion, death accurred.

29d. Date signed (Mgnth, Day, Year)

22966 7300 Van Dusen

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Thomas H. Burguieres

Laurel, MD 20707 Regional Hospital Emergency Department aure.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar Amend#26 - PerPhys - PGC3-16 Certificate of Death 1. Decedent's Name (First, M 2. Date of Death 3. Time of Death Day Year **Physician**  $\mathbf{P}^{\mathsf{M}}$ JAMES MAURICE TAYLOR 3/6/2010 /Medical :40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2021 BROOKS DRIVE # 506
5. Social Security Number 6. Sex DISTRICT HEIGHTS PRINCE GEORGE'S 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Director Washington, DC 4/23/1948 578**-**64-4257 61 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modical Examiner must be notified all 1 X Yes 2 No Directo DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3325 Stanton Road SE # 204 20020 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ 3 Widowed 4 Divorced United States Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, In "Mediconce. Elementary/Secondary (0-12) College (1-4or 5+) 12 Ink Maker <u>Federal Government</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Maurice Taylor Sr. Deloise Hawkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mary Taylor / Wife</u> 2021 Brooks Drive # 506 District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/2010 | Suitland, Maryland Lincoln Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Errier the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAGE 41 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown signed I . Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy this certificate 1 ☐ Yes 2 No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home ••• Assidence 6 Other (Specify) House Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA dire 1 ☐ Yes 2 No ٩ Date of Injury (Month, Day, Year) After t Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A pletely filled in by the fu 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

Registrar

State

d (Month, Day

MAR 1 8 2010

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Trem 23a per phys G901 3/30/10 dk
State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** LAWRENCE F. THOMAS 3/18/2010 11:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, 1 M 2 □ F Months Days Hours Min Director 217-12-5054 87 8/10/1922 **MARYLAND** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 3a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Directo MARYLAND TALBOT **BOZMAN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a 27766 ALMOST NEAVITT RD. BOZMAN, MD 21612 21612 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 ₩ Widowed 4 Divorced Year or Dates: 1940 - 1946 "natural" WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OIL BURNER MECHANIC **PETROLEUM** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P VICTOR THOMAS SARA TULL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE RIES / DAUGHTER 7886 QUAKER NECK RD., BOZMAN, MD 21612 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 permit. Page Department o Important: If any injury or once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/19/2010 MID SHORE CREMATION CENTER CAMBRIDGE, MD 21. Signature of Funeral Service 22. Name and Address of Facility MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metast Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off signed by the attending physician and defeached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has, this certificate 1 □Yes 2 🖳 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 ☐ No Hospice ပ္ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Schillu promi State Registrar

DIC DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year 3,2010 0123 Teresa March Vasquez 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 64 17,1945 El Salvador July Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Takoma Park Montgomery 1 Yes 2 □ No 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 20912 El Salvador 6710 Red Top Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican. etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 X Yes 2 □ No Specify: Specify: 3 Widowed 4 Divorced El Salvadoren White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francesca Vasquez Jose Reyes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6710 Red Top Road

Date

3/13/2010

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Souls

Takoma Park, Md. 20912

20c. Location - City or Town, State

Germantown, Md

Approximate Interval Between Onset and Death

Year

2 No

29d. Date signed (Month, Day, Year)

Department of Health Important: If item 27 any injury or other troops. **Physician** /Medical

Examiner

**Physician** 

/Medical

Examiner

none

MD

20a. Method of Disposition

29b. Signature and title of certifier

HAMMIN , HD

Maria M.Parada/Daughter

1 Burial 2 Cremation 3 Removal from State

5 ☐ Other (Specify)

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

show

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death

72 hours after

Maryland 21215-0036

altimore,

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Division of Vital Records,

Hospital

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Wedical Evanding in the matthe

is marked other than

Health a

Pages 1 and 2 should be 1 nent of Health and Mental

burial-trans and attending physician for use as the buria the detached s been signed by should be detach has page 2 certificate !

Examiner Physician/Medical \$ Completed funeral director, Be Certification: To After this al or Attendir s after death. Il Director: Ai filled in within 24 hours a

To the Funeral C

completely filled

21. Signatur PHYCEP ACTOR TOWARDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. Immediate Cause (Final DYSFULCTION MULTIORGAN disease or condition resulting in death) Due to (or as a consequence of): DISTREM SYNDROME RETPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Community Acquired Pheumonia. resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 / Ho 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

WASHINGTON ADVENTIST HOSP, TAKOMA PARK, MD-20912. SHAUD SHAMIM 31. Date filed (Month, Day, Year) 3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-50284

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°10 Nukhim Vakser March 10:02 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Months (Month, Day, Year, Director 215-45-2888 Dec. Ukraine Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Ves 2 K No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16125 Crabbs Branch Way, 20855 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ۾ 1 Never Married 2 K Married 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 | h and Mental Hygiene. **7 is marked other than "**n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Manager Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ ge 1 and 2 should be nt of Health and Mer : If item 27 is marke Vakser Ester Shwartzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyubov Vakser/Wife 6125 Crabbs Branch Way, #22, Derwood, MD. 20855 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery 3/18/2010 Germantown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Acute Myocardial Infarction disease or condition resulting in death) minutes Medical Due to (or as a consequence of): Examiner Acute Cardiac Arrest minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial Physician/Medical death certificate be use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Year Day the a 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy death? certificate 1 Yes 2 No 2 🔀 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 K No Other: 1 Yes ည 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 X Natural within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 6 00068 207 MA 9901 Medical Center Dr. Rukvilled 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VIPUL 516 2. Registrer's Signature parket

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Mayoth 12, 2010 Year 7:00 P M Belle Lasher WEISS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Brighton Gardens of Friendship Hts</u> Chevy Chase <u>Montgomery</u> If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1 □ M 2 👿 F Months 134-09-5176 89 March Pay5 Year) 1921 Commecticut Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Montgomery Chevy Chase 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 4845 Willett Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 X Widowed 4 Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumer. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Winokur Harry Lashinsky 19a. Informant's Name/Relationship (Type, Print)
Joan Marcia Weiss, Daughter 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip God) 4845 Willett Parkway, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Temple Israel Cemetery 03/16/201</u> Guilderland, NY 21. Sig ice Licensee M01603 Tareninskysshebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Senile Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a sunsequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 15, 2010 D 39947 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mona Ellis, M.D., 5530 Wisconsin Avenue #645, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) MAR 1 6 2010 2. Registrar's Signature State pares

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09820 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Virginia A. Whitehead Physician/ Month 3 2010 20:15P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton P.G. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country, Wash, D. C 8. Date of Birth 578-46-1754 (Month, Day, Year) 4-8-1930 1 □ M 2 😾 F Months Hours Min. 79 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo P.G. MD Forestville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3239 Walters Lane Funeral 20747 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Divorced 4 Divorced e 1 and 2 should be filed within 72 houns of Health and Mental Hygiene.
If item 27 is marked other than "natural other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic 6 Be 17. Father's Name (First, Middle, Last)
Russell James Banks 18. Mother's Name (First, Middle, Maiden Surname) Murney Bonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Alton Whitehead (Husband) 3239 Walters Ln. Forestville MD 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Clinton MD. Resurrection Cem 3-12-2010 4 Donation 5 Other (Specify) unt Funeral Hom Wash,D.C.20011 908 Kennedy St Was 21. Signature of Funeral Service Licensee Tunt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Anoxic disease or condition resulting in death) brain 1470 Medical Due to (or as a consequence of): Examiner As Civation preumone Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (r as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown Cerebrovasular 24b. Were autopsy findings available 24a. Was an Director: After this certificate has autopsy performed? Yes 2 X No prior to completion of cause of death?

1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pranticion T. the basis at my knowledge. Just some dat the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rot Fre 3.7.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolis Road, Snit 312 Glenndah, MD 20769 ROINTAN FARAHIFAR M.D d (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAR 1 7 2010

			For State	State of Maryland	d / Depart		lealth and M	lental Hyg	jiene2	_	09821	
	Physicia Medic		Registrar  1. Decedent's Name (First, Middle, Last)  EDITH	WOODWA		reate or E	Journ	2. Date of Dea		. O Year	3. Time of Death 4:30A M	
	Examir		4a. Facility Name (if not institution, give st. SHADY GROVE AD				Location of Death		4c. Co	ounty of Death	OMERY	
	Funeral Director		190-01-4301	м 2 🗓 F 7. Age (In yrs. la		f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth JUNE	, I 9 2	9. Birth Cour PEN	place (State or Foreign NSYLVANIA	
	laryland 3a-f show ified at	rector	Usual Residence of Decedent  10a. State	ERY 10c. City	LLE	-			10d. Inside City Limits			
	s 23a or 2 lust be no	Funeral Director	10e. Street and Number 9701 VEIRS DR	IVE		10f. Zip Code 20	0850		10g. Citizer	of What Cour USA		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.	spanic Origin? (Spen n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: WHI	etc.			
Maryland 21215-0036	vithin 72 hou jiene. er than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12) 1 2	cation completed) College (1-4 or 5+)	(Give kind	IOT use retired)	ation luring most of workin		16b. Kind	dustry ETERIA		
yland (	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) BENJAMIN SC	HLOSSER		(First, Middle, I	Aaiden Surr	name)	e) un–a vai			
, Mar	ind 2 shou lealth and im 27 is m		19a. Informant's Name/Relationship (Type ROBERT WOODWARD	ER S		,MD.20904						
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State METF	ace of Disposition of Policy Company (Company Company	ΓΑΝ CR	е́м. 3/11	/2010		tion - City or To		
Bai	permit Depar Impor any in	6 N	21. Signature of Funeral Service Ligensee	0.1			J. , INC.	TACHTMO	TON:		VE.,NW	
	Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence to (or a))).	ence of): [ A	ne mode of dyln	g, such as cardiac o	respiratory arre	st,		Approximate Interval Between Onset and Death	
	or Attending Physician: The law requires that the death certificate be executed affer death.  Jiffer death.  Jiffer this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	Due to (or as a consequence. If yes, outcome of pregnar 1  Live Birth 2  Fetal 4  Pregnant at time of degree Unknown	ncy	ctopic pregnanc ther (specify)	у		23d. Date of delivery Month Day Year			
ds, P.O.	requires that been signed t should be det		Part II. Other significant conditions conf	ributing to death but not resu	en in Part I.				he cause of death?			
Division of Vital Records,	: The law rec cate has ber ; page 2 sho	Completed by		****				24a. Was a autop perfor 1 Yes	SV	prior to co death?	e autopsy findings available r to completion of cause of th? Yes 2 \(\sumbed{\subset}\) No	
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	spital:	ER/Outpatient	Lou	er: 4  Nursing Hor		ence 6 $\square$	Other (Specify	1)	
ion of	Attending Physer death. ector: After this by the funeral di	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆	yat ? Yes 2 □ No	28d. Describe ho	w injury oc	ccurred		
Divis	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu		4 ☐ Homicide determined  29a. Certifier 1 ☒ Certifying Physic	28e. Place of Injury - At hor building, etc. (Specify) an: To the best of my knowle				City or Town	, State)		Route Number,	
	the Hos hin 24 h the Fun mpleted	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	r: On the basis of examination Practioner: To the best of my	and/or investigate	tion, in my opinic	n, death occurred at	the time, date ar	d place, and	d due to the ca	use(s) and manner stated.	
	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and my cause of the cau											
2	1		30. Name and address of person who cor DR. BRIAN CAR	ppleted cause of death (Item PENTER - SH	23a) (Type, Print IADY GI	OVE A	DVT.HOSE	TAL,	ROCKV	ILLE,	MD.20850	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar' Signat	backer							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 0 10 852AM larch FRANCENIA E. WHALEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthdav If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Min. Month, Day, Y Director 213-08-6727 lapt. Heights.MI Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No Maryland Prince George's Capt. Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7902 Beechnut Road 20743 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 K Never Married 2 ☐ Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 🗌 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Supervisor State Government should be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John F. Whalen Eva E. Countiss permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Whalen / Father Beechnut Rd. Capt. Heights, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/18/2010 | Clinton, Maryland Resurrection 21. Signature of Funeral Service Licens 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death Immediate Cause (Final NEUTROPEHIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence oil. SWERE A attending physician and for use as the burial-transit かもつからしい Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical EU ERE Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death Other (specify) ned by the a 9 Unknown g | Ilnknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be or 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \text{ Nursing Home } 5 \) Residence 6 \( \triangle \text{ Other (Specify)} \) 2 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ the

State Registrar

Whaler, FRANCENIE

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 1 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Abiodun

Goodbuck Road

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year 12:58 PM GEORGE ELMER MARCH 13 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER BERLIN

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Months 1 X M 2 □ F 221-18-4874 84 JUNE 4. 1925 DELAWARE Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No DELAWARE SUSSEX DAGSBORO 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 32363 CEA-DAG CIRCLE, UNIT 603 19939 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POSTMASTER U.S. POSTAL SERVICE 1.2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELMER B. WEST BERTHA McGEE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED B. WEST/WIFE 32363 CEA-DAG CIRCLE, UNIT 603, DAGSBORO, DE 19939 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖔 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EVERGREEN CEMETERY 3/17/10 BERLIN, MARYLAND 21. Signature 22. Name and Address of Facility 19975 HASTINGS FUNERAL HOME, SELBYVILLE, DE 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final meumonia disease or condition resulting in death) ue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 🗷 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at

death with

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permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun

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physician and s the burial-trans attending p use as should be detached certificate has breector, page 2 sl this

be executed the death certificate requires that Physician: funeral After or Attending I hours after death.

'uneral Director: Aftely filled in by the fur

To the Hospital of within 24 hours a To the Funeral Completely filled U.miR State

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown 3 Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No Medical Certification: To 27. Manno of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 ☐ Could not be determined 4 Homicide

(Check only one)

6 ☐ Other (Specify)

_					
				26. Place of Death (C	heck only one)
	Hospital: 1 Inpatient	2 ER/Outpatient	3 □ DOA	Other: 4 \( \sum \) Nursing Home	5 Residence

28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2 Medic

29d., Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

person who completed cause of death (Item 23a) (Type, Print) 30 Name and address of Healthway Dr Berlin MD 21811 9733

31. Date filed (Month, Day, Year) MAR 16

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 [] | [] State of Maryland / Department of Health and Mental Hygiene

Becky Louise W		1- For State	Stat	te of Maryla		oartment of ertificate of		and I	Mental		Pon No.	20	1 0	0 0 0 0
Physici	an/	1. Decedent's Name								2. Date of De Month	Reg. No. eath Day	Year		3. Time of Death
Medical Exami	iner								March 23, 2010				1603 hrs	
)		4a. Facility Name (if r		-	umber)		4b. City, Tov Prince I			eath		c. County of Calvert	Death	
Funeral		5. Social Security Nu		Sex	7. Age (In yrs	s. last birthday)				r 24Hrs. 8. Date of Bir			9. Birth	nplace (State or
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OX 68760 eath certificate b attending physi	Physician/Me	23b. Was decedent property past 12 months?	egnant in the	1 Live b	oirth nant at time of d	death	al death	3E	Ectopic preg	gnancy		Month	Da	y Year
Box e death c the atten ed for us	Sic	1 Yes 2 No	9 V Unknow			oeatri 5 Oth	ner (Specify,	)						
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	Medical	(Check only		ician: To the besi ner:On the basis o	of examination	_								
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	ŀ	30. Name and address	s of person wh	o completed caus	se of death (Iter	m 23a)	- 1							
		Melissa Brass	sell, MD	Assistant Med	dical Exami		enn Stree		imore, M	D 21201				
		31. Date filed (Month,	Day, Year)		egistrar's Signat	ture A	HORSEL -	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Manyland 3 Spartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month lice OST 1:00PM Medical marc 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death of Maryland medica University altimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country Virginia Min. 231-34-4750 1 □ M 2 😿 F Months Days Hours (Month, Day, Director une Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Virginia Portsmouth 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Crescent Funeral 148 Riverpoint 23707 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Jackson Memorial permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Church Church Baptist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Holderfield Anna McLeod Bessie Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21286 1016 Cowpens Ave. - Daughter Ann Yost Brad 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Alive Branch Cem. Mar. 19, 2010 20c. Location - City or Town, State 1XBunal 2 ☐ Cremation 3 ☐ Removal from State Portsmouth, 4 Donation 5 Other (Specify) ture of Judgraf Service Lightson

David 21. Signature of Jur 22. Name and Address of Facility Academy Auc Weber per dvr Louing Funeral Home 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) ancel Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last the burial-Physician/Medical 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires the Within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury work? 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18193 2010 march 16, Keshi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Beitmare Kosky 31. Date filed (Month, Day, Year) **MAR 3 0 2010** State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 63 Physician/ Zojo Day 6:32 RM Mildred Ziegler Κ. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1.35. 20,0 Comic If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 3, 1942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 ₺ F Hours Days Michigan 67 **Director** 216-40-3893 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 340 Carey Avenue 21804 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by 2 🖾 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/Operator Consignment Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nelson Pray Pauline Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ziegler- Husband 340 Carey Avenue MD 21804 Salisbury, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Crematory of Delmarva 3/14/2010 | Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E Main Street Salisbury, MD 21804 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only of munications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a z nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Dav Unknown Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 03-13-10 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

GREGORIOM. BE

MAR 15 2010

L030

5302 CHINABERRY DR., SALISBURY MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc 9901 3-31-10 yt
State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Patricia Anstin 3-10PM 2 Medical 2016 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1314 McCullah St. Apt.1 Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Hours 1942 **Director** 212-42-1577 67 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1314 McCullah St. Apt.1 21217 items? S A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Nurse Home Care Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed
 of Health and Mental H
 i item 27 is marked of Unk Mae Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Joyner (Daughter) 1314 McCulloh St. Apt. 1FL, Balto., MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o Joseph Brown F7H And Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/24/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ small cell Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed this certificate 2 | No 1 Ves 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence Hospital: 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 Tes Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 068198 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SABALINGS FROM EPD 7 2322 DRIEMS ST., BALTIMORE, MD 21224 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH ALTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 1740 N. Gay St. Social Security Number If Under 1 Year \_\_If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1**x** M 2 □ F Months Days Hours (Month, Day, 78 40 228 6276 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 □ No MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 1740 N. Gay St. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Y Yes 2 If Yes, Give3 / Year or Dates. Baltimore, Maryland 21215-0036 1955-3/1958es 2 $\square$ xNo Specify Specify:black Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)  $12 \pm h$ EVS Supervi <u>St.Joseph Hospital</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Lamkin Guss Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ser) 3 Devlon Ct. OwingsMills, Md 21117 Patricia A. Miller (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from Stat ☐ Donation 5 ☐ Other (Specify) Apr.7,2010 OwingsMills, Md. Garrison Forest Signature of Funeral Service Licensee calvin B. Scruggs Funeral Home 1141 St Balto.Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final CASVOW Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy death? After this certificate | 1 Yes 2 No Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D47934 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUTIMORE NO 21207 DATHERS

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

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Amend #1, per MD g901 3/31/10 TT amend item 5 per inf g903 5-10-10 vt.

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Year BLAKEY, **Physician** 2010 1:20 PM James Blakey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crescent Cities Center Prince Georges Riverdale 5. Social Security Number Birthplace (State or Foreign Country)
 Virginia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Vear Hours Months Davs 1 □XM 2 □ F 85 31,1924 <del>175</del>-22-7789 Director Aug. Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County show traumatic event, the Medical Examiner must be notified at MD Hyattsville Prince Georges 1 X Yes 2 □ No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 4915 Eastern Avenue # 102 20782 United States 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★□Yes 2□No If Yes, Give WW II Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black ģ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. sm 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Tailor Textile 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie Fields Unkown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16979 Horton Court
Dumfries, VA 22025 19a. Informant's Name/Relationship (Type. Print) Michelle Blakey Walker/Daughter permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. Baltimore, 20b. Place of Disposition (Name of George Complete Comple 20c. Location - City or Town, State 20a. Method of Disposition March 19 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2010 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COLON CANCER WEEKER METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION NKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): NKNOWN MGLLITUS law requires that the death certificate be executed DIABETES attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö ed by the a 9 I Unknown 9 Unknown signed by the bestach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 5 DISGASE HRONIC KIDNEY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy Physician: The meg 2 X No certificate of Vital 1 □Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Language 4 La 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D6063978 2010 Name and address of person who completed cause of death (Item 23a) (Type, Price 11 PM SYED), 7525 GREEN WM CTR DRIVE, GREENBELT, MD 460 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar Denua,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Hours Yrs. 216-40-1322 67 **Director** Oct. 11, 1942 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Examiner must be notified Howard MD Marriottsville 10e. Street and Number 10f. Zin-Code 10g. Citizen of What Country? ö or items 23a 11834 Ramsburg Road Funeral 21104 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify Specify: White þ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education or other traumatic event, the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Contractor Home Improvements other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked Wilbur Theodore Butts ၉ Edith Louise Marsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Joseph Patrick Butts/Son 415 Edgewater Road, Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 4/2/2010 Odenton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Pan 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OLON Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 X No 1 Tes 2 X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes death. Accident 2 🗌 No s after death the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Numbar or Rural Route Numbar, City or Town, State) filled in by 4 Homicide Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely f (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifing

State Registrar

AA 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

MD

MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0983 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1015 NANCY LEE BARTENFELDER 2010 3 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAl CENTER Baltimore Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) 71 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 23, 1938 Birthplace (State or Foreign Country) 1 □ M 2√F Months Days Hours Min 219~26~5733 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4564 Ridge Rd. 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify Specify: White **¾**Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore County 12th grade N/A School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Wilson Mildred R. Mvers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Joseph Bartenfelder (Son) 4803 Royahn Avenue Baltimore, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Parkwood Cemetery April 1, 2010 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Sgr ture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonio disease or condition resulting in death) Due to (or as a consequence of): .O.P. 0 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

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Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Experiment must be notified at once.

and ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

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Division of Vital Records, P.O. Box 68760.

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of death	5 Other (specify)
Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause giver
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ted	ATTICLI FIDE	ritation,	<u>C.H.D</u>	J. C. 17. F	- 1 1 Yes 2[	No 3 Probably 4 Unknown
Complete					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Other: 4 □ Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
Certific	3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, fa	actory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
edical	29a. Certifier 1 ☐ Certifying Pr (Check only one) 2 ☐ Medical Exar	nysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occi ation and/or investig	urred at the time, date and pla ation, in my opinion, death oc	ace, and due to the cause(s courred at the time, date and	) and manner as stated. I place, and due to the cause(s)
5	20h Signature and title of certifier			20s License sumber	and Dec	a singer (Manth Day Voor)

	one)					
29b.	Signature	and	title	of	certi	1

tion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

069066

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 FRANKLIN Square DR Balto md DR Mich elle Ann Cardona 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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,		4a. Facility Name (if not institution, give Good Samaritan Hospital	e street and number)	4b. C	ity, Town, or Locatio		march 2 ty	4c. County of Dea	eth
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I		altimore Under 1 Year   If Ur	nder 24Hrs.	8. Date of Birt	9. E 4/25/1961 sore	Birthplace (State or
Director		143-54-3814 1 Usual Residence of Decedent	M 2XF	48 Yrs. M	onths Days Hou	urs Min,	03/24	2010 Fore	country) NJ
w any		10a. State 10b. County		, Town or Location					10d. Inside City Limits  1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number	<u> </u>	Himore 100	. Zip Code		10	g. Citizen of What Co	
th the Maryland 23a or 28a-f sho		1531 Argonne Dri	ye.		21218			USA	
fler death wi	y Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year	If Yes, s	cedent of Hispanic Copecify Cuban, Mexico	an, Puerto Ri		14. Race - Ame White, etc.	erican Indian, Black,
hours a "natura	ted by	15. Decedent's Education (Specify on		16a. Decedent's Us during most of	sual Occupation (Given for working life, DO NO	ve kind of wor	rk done d)	16b. Kind of Busines	s/Industry
5-0036 led within 72 Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Super	visor			Food Se	rvice
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_ 5 5 5 6		20a. Method of Disposition  1  Burial 2  Cremation 3	20b.	Place of Disposition crematory or other pl	Name of cemetery,	1, '	Date	20c. Location - City of	or Town, State
드스링트님		4 Donation 5 Other Specify:	1, K	ing Part	۷	3/3	)/16	Kaltimore	Maryland
Balti permit. Departri Imports injury o	ł	21. Signature of Fune all Service Licens	Helne	Va La	and Address of Faci	ne. E.S	4405	GOVE KOA	a land 21212)
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uted d ansit	_		due to (or as a consequence o	of);					
Division of Vital Records, P.O. Box 68760, To the Hospital or affecting Physician: The law requires that the death certificate be executt Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial -tran	Physician/Medical		AMENDED 23a,27, per ME,	ner ME gg	02 4/20/1 1 <b>g901 3/</b> 3	31/16	 TT		
68760, certificate be nding physica	Me.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg			pic pregnanc		23d. Date of delive Month	ry Day Year
Division of Vital Records, P.O. Box 68760, rel or Attending Physician: The law requires that the death certificate b its after death.  al Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the bu	sicia	past 12 months?  1  Yes 2 No 9 ✓ Unknown	4 Pregnant at time of de			Pio Piogramo			Day Ivan
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u		Part II. Other significant conditions		esulting in the underl	ying cause given in l	Part I.	23e. Did tob	acco use contribute t	o the cause of death?
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n of ding Pt After funeral	no.	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Wo	_ [	d. Describe ho	ow injury occurred	
/iSion r Attend ter death. irector: n by the f	Certification:	2 Accident Investigation	28e Place of Injury - At he	ome, farm, street, fac			8f. Location (\$1	reet and Number or R	tural Route Number, City
Div	Certi	4 Homicide determined					or Town, Sta	ate)	
Division of Vital Division of Vital Division:  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical		n: To the best of my knowled On the basis of examination a	-					
To To con	ĕ	29b. Signature and title of certifier	and manner stated.		29c. License numbe	er		29d. Date signed (M	onth, Day, Year)
		his his.	, ~>		O.C.M.E.			March 25, 2010	
		<ol> <li>Name and address of person who ce Ling Li, MD Assistant Me</li> </ol>	edical Examiner 111	Penn Street, Ba	altimore, MD 21	1201			
		31. Date filed (Month, Pr. Year)	10 32 Agistrar's Signatu	1. back					
Regist	rar	MMN 0 - 20	المار الما	4/1					

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			1. Decedent's Name (First, Middle, Last)		2. Date of Dear	th	3. Time of Death
	Physicia Medio		THOMAS W. BURRUSS		Month MARCH	Day Year 24, 2010	1350 M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
				SILVER SPRING		MONTGOME	RY
	Funeral			Months Days Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign
	Director		Usual Residence of Decedent		NOV. 18	3, 1923 VTRO	STNIA
	and show	ō	10a. State 10b. County 10c. City, Town or Local VA	ition			10d. Inside City Limits
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	the the to or 2		10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	untry?
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	item item		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever in	as Decedent of Hispanic Origin? (Speres, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
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Maryland	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Yelle alth and Mental Hygiene.  Yelle marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	오	EZEKIEL L. BURRUSS	ETHEL N	MALLORY		
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saltimore,	gela toff ifite oroti		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, crema	tion (Name of tory or other place)	Date	20c. Location - City or 1	own, State
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<b>7</b> 2 2 5	eral d	은 ::	1 X Inpatient 2 ☐ ER/Outpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of	3 □ DOA   4 □ Nursing Ho	•	ence 6 Other (Specification)	y)
	ath. : Afte	cat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 🗆 Yes 2 🗆 No	LOG. Describe no	w пригу оссилей	
VISION	s after death.  I Director; After this d in by the funeral d	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street	t, factory, office	28f. Location (Str	reet and Number or Rura	l Route Number,
2 2	s afte		building, etc. (Specify)		City or Town	, State)	
Hospital or Attending Physician: The law requires that the death conflicts be excepted	within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investig.	cured at the time, date and place, an	d due to the caus	se(s) and manner as state	ed.
1 4	hin 24 the F	Me	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the	cause(s) and manner as s	tated.
F	S o o		29b. Signature and title of certifier	29c. License number D68150	2	9d. Date signed (Month, 3/25/10	Day, Year)
7			Verix Jack			-, 25, 10	
(	01/		30. Name and address of person who completed cause of death (Item 23a) (Type, Prir NEJIB SIRAS MD 1500 FORESTGLEN RD., \$	'	2091	0	
	Stat				/• ZUST		
	Registra	_	31. Date filed (Month, Day, Year)  MAR 3 1 2010  32. Fegistrar's Signature.	Wel .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Buchheister Florence 1:00 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville 8308 Overmont Road Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2, 1919 **Funeral** 9. Birthplace (State or Foreign 1 M 2XXF 212-30-2701 Director Yrs. Maryland Usual Residence of Decedent 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville MDBaltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8308 Overmont Road 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Woolwarth permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hannah White Henry Dieter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelley Drasal - Grandbaughter 8308 Overmont Road, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
FVans Funeral Chapel & Cremation Services Belai 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State March 31,2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Crenation Services — 1 8800 Harford Road, Parkville, Maryland 21234 - Parkville 23a. Part 1. En et the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reshrifallure. I ist only one cause on each line. Approximate Interval Between Onset and Death Physician/ hterioselevolu disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a sunsequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2XXNo 9 Unknown ed by the a detached f 9 Unknown s been signed k 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 24 hours after death.

Euneral Director: After this certificate has been sign there of the property of the thing the page 2 should be eted filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2**X X**Vo Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending injury 1 ☐ Yes 2 ☐ No. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined completed filled in Medical 29a. Certifier 1 X Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-29-10 121022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

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1602 BERA

10-02424 Moses Baker. IV Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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cal Exami		Moses Baker IV				March 27, 2	2010 4c. County of Dea	
		Facility Name (if not institution, give street and number)     Sinai Hospital		y, Town, or Loca Itimore	ation of Death		4c. County of Dea	atri
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If U	Inder 1 Year If	Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or
Director	- 1	212-31-4666 1 X M 2 F 22	140	nths Days I	Hours Min.	08-17		eign Country) GA
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and show	5	MD Baltimore	Owings Mil	ls		140	g. Citizen of What Co	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	4	10e. Street and Number 7 Fhlox Circle, Apt D	10f.	Zip Code 21117		10	g. Citizen of What Co USA	ountry ?
th the 23a of notified		11. Marital Status 12. Was Decedent Ever in U.S.	13 Was Dec	edent of Hispani	c Origin? ( Spe	cify Yes or No-		erican Indian, Black,
ath witems	Funeral	1 Never Married 2 Married Armed Forces?		ecify Cuban, Me			White, etc	
fter de		1 Yes 2 \( \triangle \) No 3 \( \triangle \) Widowed 4 \( \triangle \) Divorced If Yes, Give Year or Dates:	1 Yes	2 X No sp	ecify:		Specify:	can-American
ours a	g p	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Us	ual Occupation ( working life, DO	Give kind of wo		16b. Kind of Busines	s/Industry
6 72 h an "n cal E	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Data En	_		C'	Manpower	
withir jene.	Ę.	12th 17. Father's Name (First, Middle, Last)			fother's Name	First Middle M	aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	Be	Moses Baker III			Deneen Ti		,	
212 buld be Ment mark	ToB	19a. Informant's Name/Relationship (Type, Print )		ress (Street an	d Number or R	ural Route Numi	oer, City or Town, St	ate, Zip Code)
MD and 2 sho m 27 is aumati		Deneen A. Crawford/ Mother			<del>~</del>		, MD 21117 20c. Location - City	Taura Stata
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.			ace of Disposition ( ematory or other pla National Ce			Date -2010	Laurel, MD	or rown, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Specify:		_			,	- D-15 C
Baltimo permit. Page Department o Important: injury or oth	1	21. Sign ture of Funeral Service Licensee					MD 21133	or Balto. Co.
		23a Part Enter the disease, or complications that caused the death. I						Approximate Interval
Physician /Medical		fellure. List only one cause on each line.						Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound of Chest  Due to (or as a consequence of):						
		Sequentially list conditions, b.						
	iner	if any, leading to immediate  Cause. Enter Underlying Cause  C.	:					
	Examin	(Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of)	1					
ecuted and - trans	alE	d						-
60, ate be ex hysician e burial	Medical	UNPENDED AMENDED					23d. Date of deliv	vecv.
Division of Vital Records, P.O. Box 68760, the Hospital or Abrital Precords, P.O. Box 68760, hin 24 hours after death. The law requires that the death certificate be executed the Table death. The Inversal Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/M	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	ancy 2 Fetal de	eath 3 1	Ectopic pregna	псу	Month	Day Year
Box 687 death certificate attending ped for use as the	icia	past 12 months?  4 Pregnant at time of dea	ath 5 Other (	Specify)				
Bo he dea y the a	Physician/	Part II. Other significant conditions contributing to death but not rea	sulting in the under	lvinc cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
i, P.O. E ires that the d signed by the	ρ	Falt is Ottler significant conditions Continuing to dood sattle for	551g	,,g g		1 Yes	2 <b>✓</b> No 3 F	Probably 4 Unknown
ords, w requires s been sig	Completed					24a. Was a		autopsy findings available
COL law re has b	ם				<del></del>	autops perfor	med? death	
Division of Vital Records, tall or Attending Physician: The law requir urs after death.  All Director: After this certificate has been selled in by the funeral director, page 2 should I led		25. Was case referred to medical		26.Place of	Death (Check of	1 Yes 2	2 No 1 🗸	163 2 110
Vital Interpretation of this certification.	o Be	examiner? 1 V yes 2 No  Hospital: 1 Inpatient 2 V	ER/Outpatient 3	DOA Oth	ner <sub>4</sub> Nursin	g Home 5	Residence 6 0	ther:
n of V ding Phy After th funeral o	-	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury a		28d. Describe h	now injury occurred	
ion fendin eath.	텵	1 Natural 5 Pending Mar 26, 2010 Mar 26, 2010	2307 hrs		2 ✔ No	•		
Division pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At ho		ctory, office build		or Town S	tate)	Rural Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	8	4 Homicide determined (Specify) Multi-Family 29a. Certifier 4 Continue Physicians. To the best of my knowledge					Road Apt. 2C, Ow	
To the Hos within 24 h	<u>8</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledg one) Wedical Examiner: On the basis of examination ar	ge, death occurred a nd/or investigation,	at the time, date in my opinion, de	and place, and eath occurred a	due to the caus t the time, date	e(s) and manner as a and place, and due to	o the cause(s)
To the within 2 To the complet	Medical	and manner stated.  29b_Signalure) and title of certifier		29c. License n			29d. Date signed	
	_	( ) ( a. l. Parker)		O.C.M.	E.		March 27, 201	0
		30. Name and address of person who completed cause of death (Item						
		Laron Locke MD. Assistant Medical Examiner	111 Penn Str	reet, Baltimo	re, MD 212	01		
	tate		re	3.02				
Regi	strai		1. par					
DHMH 17 Rev 1/	2001	OCME	ORIGINAL					

Division or Vital Records, P.O. Box 68760,	7	Baltimore, M
to Hospital or Attending Physician: The law requires that the death certificate be executed	Phy /N Exa	permit. Pages 1 and 2
1.24 Hours after death. e Funeral Director: After this certificate has been signed by the attending physician and	/sid Med am	Important: If Item 27 I
letely filled in by the funeral director, page 2 should be detached for use as the burial-transit		any injury or other tra

			For State		State of M	arylan	-	irtment of H <i>rtificate of L</i>				21	10	09836
			Registrar  1. Decedent's Name (Fir	rst, Middle, La	ast)			timoate of E	Journ		2. Date of Dea			3. Time of Death
п	Physici /Medic		Roseanne	e E. B1	akeney					1	MAR	A2	9010	1158 M
4	Examin		4a. Facility Name (If not		ve street and number,	0	1	4b. City, Town, or	Location of	of Death	4	4c. Coun	ty of Death	
(4)		4.	1281	MA	gothy	120	•	PAS	Ad	eni	4		FF 1-1	
í.	Funeral Director		5. Social Security Number 397–18–979		Sex 7. A 1 ☐ M 2 🌠 F	ge (In yrs. 8	last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birt (Month, Day Nov 27,	1924	9. Birthp Coun Mary	lace (State or Foreign try) and
	pu »		Usual Residence of Dec	cedent c. County		10c Cit	y, Town or Lo	cation				1	0d. Inside City Limits	
	MD Anne Arundel Pasadena  10e. Street and Number 10e. Street and Number 1281 Magothy Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Chief Maying Pie											1 ☐ Yes 2√☐ No		
	the N 28a-	rect	10e. Street and Number		dilder		1 45	10f. Zip Code				10g. Citizen of	f What Coun	try?
	h with	Funeral Director	1281 Magot	hy Roa	ıd			2	1122			US	A	-
	er mu	ner	11. Marital Status		12. Was Decedent	Ever in U.	S. 13.	Vas Decedent of Hi f Yes, specify Cuba	ispanic Ori	igin? (Spec	ify Yes or No-		ace - Americ	
36	### 10a. State   10b. County   10c. City, Town or Location   Pasadena   10c. City, Town or Location   10c. City, Town or Location   Pasadena   10c. City, Town or Location   10c. City or Lo								,	Spec		ite		
5-0036	hour turai'	ed b		Decedent's E			16a. Deced	dent's Usual Occup	ation			16b. Kind of	Business/Inc	iustry
215	in 72 in "na Medic	Completed	(Specify or	nly highest g	rade completed)	5+1	(Give life. I	kind of work done of DO NOT use retired	during mos d)	st of working	7			
2121	d with giene er tha , the	E	Elementary/Secondary 12	y (0-12)	College (1-4or	~ <del>5</del> +	h	ematologi	lst			hea	11thca	re
Maryland	d be file ental Hy ced oth c event	Be	17. Father's Name (First Raymond I		,					,		Maiden Surna nette J		
ary	shoul nd Me mark	T <sub>0</sub>	19a. Informant's Name/	/Relationship	(Type. Print)		19b. Mailir	g Address (Street	and Numbe	er or Rural	Route Number	er, City or Tow	n, State, Zip	Code)
Ž	and 2 ralth a 27 is		Baltimore '	Washin	gton Med (	tr	301	Hospital	driv	e Gle	n Burn	ie, MD	2106	1
ore	of He of He f Item		20a. Method of Dispositi		☐Removal from State		Place of Dispo emetery, crea	sition (Name of natory or other plac	e)	Da	te	20c. Location	- City or To	wn, State
altimore,	Pag tment tant: I		4 ▼ Donation 5 □	Other (Spec	ifu)									
Bal	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		21. Signature/of Funera	1 9	- 1 /as/15	•	Ι.	Name and Addres tate Ana Saltimore	MD	2120	1		imore	Street
D	- 11		23a. Part1. Enter the di shock, or heart fai	isease, or cor ilure. List onl	nplications that cause y one cause on each	d the deat	h. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)		a Arte	rios	ckro	stie /	tc AT	rt 1	Dist	AS &	-	Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):	,						
The State of the S	, c A	e.	Sequentially list condition if any, leading to immed	ons, diate	b. — Due to (or as	a conseq	uence of):							
	cuted d ansit	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	g y	C									
o,	e exection and an and an and and and and and and	Exa	resulting in death) Last		Due to (or as	a conseq	uence of):							
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical			d									
9	ding b	/Me	IF FEMALE:		23c. If yes, outcome	e of oregon	ancv					004 5	Nata of dalling	
Box	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pre- in the past 12 mon 1 ☐ Yes 2 ☐ No	nths?	1□Live birth 4□Pregnant	2 🗆 Feta	Ideath 3	Ectopic pregnancy Other (specify)	′				Date of delive Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown	, <u> </u>	9□Unknown									
S, F	es tha gned I	by P	Part II. Other significan	nt conditions	contributing to death	out not res	ulting in the u	nderlying cause give	en in Part i	i.	23e. Did to			ne cause of death?
Vital Records,	equir	ted									10	Yes 2 No	3 Prob	abiy 4 Unknown
ec		Completed									24a, Was autor	osy	prior to cor	psy findings available mpletion of cause of
al F	stcian: The law certificate has b				Τ						1□ Yes	rmed? 2/XLNo	death? 1 ☐ Yes	2 □ No
Vit	Physician: r this certific ral director,	Be	25. Was case referred t examiner? 1 XYes 2 No	to medical	Hospital:	iont 2	ER/Outpatier	nt 3 □ DOA Oth	or:		(Check only o		NI (O)	-
0	g Phy er this eral d	n: To	27. Manner of Death		28a. Date of In	ury	28b. Time o					dence 6 Co		y)
ion	Attending r death. sctor: After by the funer	ation	2 Accident	☐ Pending investigation		ay rear)	Injury		k/ Yes 2□	No				
Division or	after des Directo	tific	3 ☐ Suicide 6 4 ☐ Homicide	Could not l	28e. Place of if	jury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28	If. Location (S City or Tox		nber or Rura	d Route Number,
D	pital c	Se	20a Cartifica	Captibulan	hyeining To the book	t out pour law -	wlodoo	h accurred at the 11	mo det-	nd place	nd due to th	021100(0) 1	manner	tated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:			Physician: To the bes aminer: On the basis and manners	of examina								
	To the within 2 To the comple	Me	29b. Signature and title	of certifier	~	De	puty	29c. Licens	e number	- 12- 1	/	29d. Date sign	ned (Month,	Day, Year)
			Mille	lo-	F. Ale	Me	0	Print)	160	227		3/	23/	10
			30. Name and address	of person who	2		n 23a) (Type,	Print)	An	non	ic.A	21	03	5
	Sta	te	31. Date filed (Month, D		32. Regis	trar's Signa	ature	1	111	,			-	
	Regist		MAR 3	1 2010	Deven	J	yann							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department Certificate			iene 2010	09837
	Physicia		Decedent's Name (First, Middle, Last)     Lucien Morton Biberman		2. Date of Deat		3. Time of Death 12:10 pM
	Medio Examin		4a. Facility Name (if not institution, give street and number)  4b. City,	Town, or Location of Death	- rate or	4c. County of Death	
		Ш		er Spring  1 Year   If Under 24 Hrs.	0.0.4.60.4	Montgomer	-
	Funeral Director		027–14–5996 1X M 2 🗆 F 90 Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, May 31,	Year) 1919 Penr	nplace (State or Foreign Intry) Isylvania
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Aarylar Ba-f s tiffed	recto	MD Montgomery Silver Spring				1 ☐ Yes 2X No
	h the Ragor 2	al Di	10e. Street and Number 10f. Zip			0g. Citizen of What Cou	untry?
	ath wit	Funeral Director	3731 Glen Eagles Drive 209	U6 ent of Hispanic Origin? (Spec		USA	in Indian
Š	fter de		1 Never Married 2 Amarried Armed Forces? 1 Yes 2 No	fy Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - Ameri Black, White	, etc.
ş	ours a atural' cal Ex	Completed by	3 Widowed 4 Divorced Fear or Dates.  15. Decedent's Education 16a. Decedent's Usual			Specify: Whit	
212	in 72 h e. nan "n	ldmc		done during most of working		16b. Kind of Business I Institute f	
72	d with dygien ther th	0	5+ Physicist 17. Father's Name (First, Middle, Last)			Defense Ana	ilysis —————
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M. Acal Examiner must be notified at	10.	Louis Biberman	18. Mother's Name Eva Kerns		laiden Surname)	
Tary	should and N is ma aumat			(Street and Number or Rural			
	and 2 Health tem 27		Virginia Hewitt Biberman/wife 3731 Glen 1  20a. Method of Disposition (Name	Eagles Dr. Si			
Ē	Page 1 nent of int: If it		1  Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	her place)		20c. Location - City or T Woodbine,M	
Baitimore,	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licenses 22. Name and 50 ing Hd	Address of Facility OME Cremation	Service	e P.O. Box	784
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode	L. Heckrotte of dying, such as cardiac or	PA (	Clarksville st,	Approximate
1	Physicianz		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pulmonary Hypertension				Onset and Death 2 Years
	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury				
	ate be executed physician and the burial-transit	Exa	that initiated events c. Due to (or as a consequence of):				
2	ate be hysicia the bur	dical	d				
08/	ding b	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			004 P-1644	
ž	death c e atter ed for u	Physician/Me	in the past 12 months?  1  Live Birth 2  Fetal death 3  Ectopic pr 1 Yes 2 No  4  Pregnant at time of death 5 Other (spe			23d. Date of deliver Month	very Day Year
	at the d by th letache		g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I	22a Did tah	acco use contribute to t	the enurse of death?
z,	luires the	Completed by	Hypertensive Heart Disease			s 2 No 3 Pro	
Division of Vital Records,	law rec has bee e 2 sho	mplet	Malabsorption due to complications of Crok	m's Disease	24a. Was an	y prior to co	opsy findings available ompletion of cause of
<u> </u>	n: The ificate or, pag	e Co	Hypertensive diabetic nephrosclerosis 25. Was case referred to medical	OC Disease & Death (Obs.)	1 🗆 Yes 2	ied? death? IX No 1 ☐ Yes	2 🗆 No
VITE	nysicia iis cert direct	To B	examiner?  1 A Yes 2 No  Hospital:  1 Inpatient 2 ER/Outpatient 3 DO/	26. Place of Death (Check of Other:		nce 6 Other (Specif	v)
101	ling Ph		1 X Natural 5 □ Pending   (Month, Day, Year)   Injury	c. Injury at 28 work?	8d. Describe hov		
SIO	Attenc r death ector: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined determined. 28e. Place of Injury - At home, farm, street, factory,	1 Yes 2 No	8f. Location (Str	eet and Number or Rura	l Boute Number
5	ital or urs afte ral Dire		building, etc. (Speciny)		City or Town,	State)	ļ.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, death occured at the basis of examination and/or investigation, in more only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in more practionary.	y opinion, death occurred at t	he time, date and	place, and due to the ca	use(s) and manner stated.
	To t To t			License number		d. Date signed (Month,	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	014603	_   N	March 29, 2	U1U
			Theodore C. M. Li, M.D. 3301 New Mexico Av	re. NW Washin	gton, D.	.C. 20016	
	Stat Registra	e	31. Date filed (Month, Day, Year) 31 2010 32. Registrar's Signature 1. Aug.				
			100000 00 0000				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March ZO 10 Bridges County of Death 4a. Facility Name (If not institution, give street and number) 4h. City Town, or Location of Death 0 Bnz nit Baltimore-Washington Medical Center 2-CC 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min 1 ☐ M 2 🛣 F 216-36-2461 68 June 16,1941 Florida Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7850 Cindy Drive 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 f Yes, Give 1 Never Married 2 Married 1 □Yes 2 No Specify Specify 3 X Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Owner Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zeolia Sylvester Bridges Dorothy Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Steinkamp (Daughter) 3804 MacTavish Avenue Baltimore, Maryland 21229 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 DOther (Specify) Atlantic Cremation 03/27/10 Glen Burnie, Maryland 21. Signature of Functal Service Licensee 22, Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 Fast Patapsco Avenue Baltimore, Maryland 21225 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consumnce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 D No 2 No 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

23a or

Items

Po,

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumetic.

Baltimore, Maryland 21215-0036

traumatic event, the Madical Experiment must be notified

Director

Funeral

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Completed

Be

2

burialattending physician for use as the buria the s been signed by should be detact icate has t certificate director this

The law requires that the death certificate be executed

68760

Box

P.0.

Records,

Division of Vital Hospital or Attending Physician;

hours after death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

within 2

Examiner Physician/Medical Completed by Be Certification: To After th funeral

9 Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 4 Natural 5 Pending 2 Accident investigation

6 Could not be determined 3 Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifie

29a. Certifier

Tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

State

Medical

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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-01	U	1	U	U	Sec.	U	

		1- For State Registrar	Certificate o		ia montan		g. No.	
Physici Medical Exam	an/	Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3. Time of Death
gedical Exam	IIIei	Charles L. Bowman  4a. Facility Name (if not institution, give street and number)		4b, City, Town, o	or Location of Dea	March 27, 2	4c. County of D	1714 hrs
		Johns Hopkins Hospital		Baltimore			n/a	
Funeral Director	11.	212 61 6773 x M 2 F 1	e (In yrs. last birthday) 6 Yr	If Under 1 Ye Months Da				Birthplace (State or Foreign Country) MD
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ition	-			10d. Inside City Limits
<b>*</b> ,	o	MD n/a	Baltin	more				1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 1401 N. Luzerne Avenue	<u> </u>	10f. Zip Code 2121	3	100	g. Citizen of What 0	Country?
r death w or items must be	Funeral			Yes, specify Cuba	n, Mexican, Puerl	Specify Yes or No- o Rican, etc.)	White, et	
urs afte tural"; aminci	d by	Widowed 4 Divorced of Divorced of Divorced of Divorced of Dates:  15. Decedent's Education (Specify only highest grade com	pleted) 16a. Decede	Yes 2 X No		work done	Specify: B1  16b. Kind of Busine	
1215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5	5+) during n	most of working life udent			n/a	,
21215-0036 muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	S	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	,	
2121; uld be fil Mental F marked c event, 1	To Be	Eddie James  19a. Informant's Name/Relationship (Type, Print )	19b. Mailin	ng Address (Stre		Oy Bown	lan per, City or Town, S	tate Zin Code)
MD 21 ad 2 should lith and Men at 27 is man	-	Delores Bowman(grandmo					Balto,Md	
		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from Sta	20b. Place of Dispos crematory or of		emetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:	KingMemo			ri12,20	10Balti	more,MD
Balti permit. Departu Importa		21 Signature of Funeral Service Licensee	Ca	Name and Addres	• Scrug	gs Fune	ral Hom	е
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter f	the mode of dying	Preston , such as cardiac	or respiratory arres	1 to Md st, shock, or heart	21213 Approximate Interval
Medial Examiner		Immediate Cause (Final disease a. Gunshot Wound						Between Onset and Death
		or condition resulting in death)  Due to (or as a conse  Sequentially list conditions,  b.	quence of):					
	iner	if any, leading to immediate Due to (or as a conse	quence of):					
n it	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
760, icate be executed physician and the burial - transit		dd						
60, ate be e ohysicia ne burial	Medical	IF FEMALE: 23c. If yes, outcom	ne of preopancy				23d. Date of deli	ven
ox 68 ath certif attending or use as	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at t	2 Fe	etal death 3 other (Specify)	Ectopic pregr	ancy	Month	Day Year
O. B( t the de by the ached fi	Phy	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
i, P.O. ires that the signed by	2					1 Yes	2 <b>✓</b> No 3 F	Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should I	Completed					24a. Was ar autopsy		autopsy findings available to completion of cause of
Vital Reconysician: The law this certificate has I director, page 2 s	mo		_			perform 1 Yes 2	ned? death	1?
tal Recition: The continued to the conti	Be	25. Was case referred to medical examiner?   Hospital: 1   Innation		-	e of Death (Check			
ing Physi After this	P.	1 Yes 2 No 28a. Date of Injur	ent 2 ER/Outpatient		ury at Work?		esidence 6 O	ther:
On C tending eath. or: Af the fun	ertification:	1 Natural 5 Pending Mar 27, 2010	1637 hrs		Yes 2 No	Subject shot		
Division spital or Atten tours after death neral Director: filled in by the	tifica	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, stre	eet, factory, office	building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	0	4 V Homicide determined (Specify) Side				2600 E. Oliver	Street, Baltimore	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of exam						
To To	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (	Month, Day, Year)
		(autherse)		O.C.	M.E.		March 28, 201	0
	İ	<ol> <li>Name and address of person who completed cause of de Laron Locke MD. Assistant Medical Exa</li> </ol>		n Street, Balti	more MD 21	201		
	ate	31. Date filed (Month, Day Year 3 0 2010 32. Resistrar		Ja A	more, IVID 21.	-01		
Regis	trar	MAR 30 2010 Dener	M. B. A.	acker				

Physician/ Medical Examiner

> **Funeral** Director

> > Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once,

Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician /Medical

Examiner

1 V Yes

27. Manner of Death

\_\_ Natural

Accident

Suicide

29b. Signature and title of certifie

Laron Locke MD.

4 V Homicide

2 No

5 Pending

OCME

6 Could not be

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a)

Examiner

Physician/Medical

<u>ک</u>

Completed

Be

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Medical Certification:

Director

<u>م</u>

Completed

Be

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1- For State	oe or Print i ate of Maryla	<b>n Black Indel</b> and / Departm <i>Certific</i>	OIII OI	i louitii utta	All Co Menta	ppies al Hy	giono				09840
Registrar  1. Decedent's Name (First, Midd)	e Last)	Ocitino	ale of	Death			2. Date of De	Reg. No eath			3. Time of Death
,	, ,						Month March 2	Day	Yea	r	0622 hrs
Marvin C  4a. Facility Name (if not institution	n, give street and n	umber)	14	lb. City, Town, or L	ocation of (	Oeath .	IVIAI CIT 2		c. County o	of Death	
Franklin Square Hosp				Rosedale				- 1	Baltimor		
5. Social Security Number	6. Sex	7. Age (In yrs. last bir	thday)	If Under 1 Year	If Under 2	24Hrs	8 Date of F				hplace (State or Foreign
				Months Days	Hours	Min.					untry)
214-96-7822	1 <mark>™ M</mark> 2∏F	29_	Yrs.				10/0	<u>6/1</u>	980	Ma	ryland
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	on							10d. Inside City Limits
		Too. Oity, Town	or Ecocation	011							1 XYes 2 No
MD N/	Α		Bal	ltimore							
10e. Street and Number		4		10f. Zip Code				10g. Ci	tizen of Wh	at Cour	ntry?
457 Cummings	Court			2120	1				U.S.	Α.	
11. Marital Status	12. Was De	cedent Ever in U.S.		s Decedent of Hisp	anic Origin				14. Race	- Amen	can Indian, Black,
1 X Never Married 2 M	arried Armed F	orces?	l If Ye	es, specify Cuban,	Mexican, P	uerto F	Rican, etc.)		White	e, etc.	
3 Widowed 4 Div	orced If Yes, Give Yes		1	Yes 2X No	specify:				Specify:	Вĺ	ack
15. Decedent's Education (Spe	or Dates: cify only highest gra	de completed) 16a.		's Usual Occupation		nd of wo	ork done	16b.	Kind of Bu		
Elementary/Secondary (0-12)	College (	1-4 or 5+)	during mo	ost of working life. I	OO NOT us	e retire	ed)				
12th Grade			Mı	ısician					Se	1 £	
17. Father's Name (First, Middle,	Last)		1.10		3.Mother's I	Name (	First, Middle	, Maider			
						2.5					
Marvin Cook  19a. Informant's Name/Relations	hip (Type, Print)		b. Mailing	Address (Street	and Numbe	er or Ru	<u>rlina</u> ıral Route N	Imber (	Ter.	n State	Zin Code)
ThumberlinaT									•		
20a. Method of Disposition	yrer (MO		of Disposi	Cummungs tion (Name of cem	etery.		<u>, Ba⊥t</u> Date				Town, State
1 X Burial 2 Cremation	3 Removal fi		tory or oth		,					-17	
4 Donation 5 Other Sp	pecify:	Mt.	Zior	1 Cemete	ry 0	)4/(	06/10	В	alti	mor	e,MD
21. Signature of Funeral Service	Licenses	)		oren Horen							
Jacquelina	BK	oane)	21	140 N. H	ulto	on Z	Ave.,	Bal	timo	re,	MD 21217
23a. Part I. Enter the disease, or failure List only one cause		aused the death. Do no									Approximate Interval
Immediate Cause (Final disease		unshot Wounds									Between Onset and Death
or condition resulting in death)		a consequence of):									
Conventially list conditions	b.	, ,									
Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):									
cause. Enter Underlying Cause (Disease or injury that initiated	с										
events resulting in death) Last	Due to (or as	a consequence of):									
	d										
UNPENDED	AMENDED										
IF FEMALE:		outcome of pregnancy				•		23	d. Date of	delivery	
23b. Was decedent pregnant in the past 12 months?	LIVE		2 Fet	al death 3	Ectopic p	regnan	су		Month	D	ay Year
1 Yes 2 No 9 Uni			5 Oth	ner (Specify)							
	9 Onkn					_	_				
Part II. Other significant condit	ions contributing to	o death but not resultin	g in the u	nderlying cause giv	en in Part I	l.				_	the cause of death?
						_	1 🗆 Y	es 2	<b>∕</b> No 3	Prob	ably 4 Unknown
						=	24a. Wa				topsy findings available
-								opsy form <u>ed</u> ?		nor to c eath?	ompletion of cause of
							1 ✓ Yes			<b>✓</b> Ye	s 2 No
25. Was case referred to medica examiner?					f Death (Cl	heck or	nly one)				
1 Yes 2 No	Hospital: 1	Inpatient 2 🗹 ER/O	utpatient	3 DOA	ther <sub>4</sub> N	Nursing	Home 5	Resid	ence 6	Other	

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**OCME 2006** 

28a. Date of Injury

and manner stated

Assistant Medical Examiner

Mar 28, 2010 ear)

(Specify) Single Family Home

32 Registrar's Signatur

111 Penn Street, Baltimore, MD 21201 parks

**ORIGINAL** 

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier (Check only one)

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20a Certifier 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0546 hrs

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 ✔ No

28d. Describe how injury occurred

or Town, State) 4258 Chapel Road, Nottingham, MD

28f. Location (Street and Number or Rural Route Number, City

March 28, 2010

29d. Date signed (Month, Day, Year)

Subject shot

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 9901 3/31/10 TT State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cleveland Physician/ Brian 1810 2010 Mar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hosptial Howard <u>Columbia</u> Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
ine 4, 1944 1 X M 2 D F Country) Washington, 219-40-5732 Director 65 June Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 9493 Battler Court 21045 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2X Married Completed by Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", White 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Purchasing Manager Logistics Applications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Cleveland Betty Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia C. Cleveland/Wife 9493 Battler Court, Columbia, MD 21045 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) West Arundel Crem 4/2/2010 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, M01103 Laurel, 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death accident Acute cerebrovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, Due to force a consequence of If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 24 hours after death.

• Funeral Director: After this certificate has been signed by to tend filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. pleted (Check To the I within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 66515 Mar 27 2010

State Registrar Nishi Rawat, MD 10710 Charter Dr, Suite 310, Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CURT HARVEY CREEL March 26, 2010 5:45 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8204 Gorman Road, Apt. 250 Prince George's Laurel 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min 1 □ M 2 □ F Months Days Hours 530-70-7844 Director 52 25, Oct. 1957 NV Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Evant. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 ☐ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8204 Gorman Road, Apt. 250 20707 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 Mo Ś Specify Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Creel Susann Stiver ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) spouse 8204 Gorman Avenue, Apt. 250 Katherine R. Creel Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State Arundel Crematory 3/31/2010 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser vice Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, unly one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dyspnea 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HTN years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months?
1 □ Yes 2 □ No Month 5 Other (specify) the 9 🔲 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 / No 1 ☐ Yes 1 ☐ Yes 2 😾 🎾 o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nessidence 6 Other (Specify) 1 ☐ Yes 2 📆 💢 🕽 0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury After t 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tracy Lynn Gutierrez, M.D. 7070 Samuel Morse Drive Columbia, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician**  $\mathbf{p}^{\mathsf{M}}$ EDIE CURRAN JR March 30. 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours **X** M 2□ F North Carolina January 82 245-48-2127 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 □Yes XXNo traumatic event, the Medical Examinar must be notified Director Maryland | Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò USA 21204 1721 Circle Road or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② WNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married 1 □Yes XX No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Sales marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi. th and Mental F 7 is marked otl Be Alice VanLennep Frank Edie Curran Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR 1719 Circle Road Towson, Maryland 21204 Department of Health a Important: If item 27 is any Injury or other tra Health Stacy Curran Lindsey Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Mar 31,2010 Baltimore, Maryland GreenMount Crematory □ Donation 5 □ Other (Specify) 22. Name and Address of FMittenell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a COMPLICATIONS OF LYMPHOMA OF CENTRAL NERVOUS SYSTEM MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of: Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □Yes 2 □No Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Attending 1 Natural 5 Pending spital or Attendin nours after death. neral Director: Aff y filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Hospital 29a, Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MARCH 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DANIEUT OOBERMAN, MB

MAR 3 1 2010

31. Date filed (Month, Day, Year)

6701 NCHARLES ST, SUITE 4105

32. Registrar's Signature

BALTIMORE, MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 19844 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year March えかい /Medical Eacility Name (If not institution City street and number Location of Death Examiner County of Death 7. Age (In yrs. last birthday. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√ F Months Days Hours Min 49 Director 09 07 MD 215-78-9025 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 23a 5401 Old Court Road Funeral 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ. 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade na Unemployed Unemployed and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton N. Coleman Geraldine Weedon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health au
Important: if Item 27 is
any injury or other trau Gwendolyn Penn-Daughter Demel Ct Apt 3A, Owings Mills, Md 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 4/2/10 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Will Edn March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Examiner or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Onknown 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 ☐ onknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 □No Division of Vital 2 ∏ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 D No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation hours after death. 1 ☐ Yes 2 🗆 No 2 Accident i Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title certifie completed cause of death (Item 23a) (Type, Print) 5401 old Court Road

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Marylan  1 - For State of Marylan Registrar		artment of H			iene .g. No. 2010	09845
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Funeral Director		5. Social Security Number 6. Sex 7 7. Age (In yrs 1 1 1 M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s. Tast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 02 19	Year) 9. Bir	thplace (State or Foreign ountry)  VA
land ow		Usual Residence of Decedent           10a. State         10b. County         10c. County	City, Town or Loc	cation				10d. Inside City Limits
ith the Marylan or 28a-f show	Director	MD NA	Balt	timore				1 <b>X</b> □Yes 2 □ No
with th		10e. Street and Number 2012 Ruxton Ave		10f. Zip Code 212	016	10	og. Citizen of What Co	-
r death	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Am-	erican Indian,
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and Men s marke sumatic	2	Lewis Conaway  19a. Informant's Name/Relationship (Type. Print) Daughte	19b. Mailin	g Address (Street a	${f Iva}$ ${f Fal}$ and Number or Rur		City or Town, State,	Zip Code)
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		Burial 2 Cremation 3 Hemoval from State	cemetery, crem	sition (Name of natory or other place	e) 4/3/		20c. Location - City or Baltimor	•
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T 90 = 80	0 0	23a. Palt 1. Enter the disease, or complications that caused the dea	e 43	300 Waba	ash Ave,		more, Mā	Approximate
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/Medical Examiner		resulting in death)	equence of):	V d				210
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eath certifica attending ph	/Med	IF FEMALE: 23c. If yes, outcome of pregr	nancy		•			
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ding Pr th. After th funeral		27. Manner of Death  1 Natural 5 □ Pending (Month, Day, Year)  21 Accident investigation	28b. Time of Injury	Work	yat (? Yes 2 □ No	28d. Describe ho	w injury occurred	
r Atter ter dea irector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Spec		eet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Bural Route Number,
spital o		29a. Certifier 1X Certifying Physician: To the best of my kn	nowledge, death	occurred at the tin	ne. date and place.	and due to the ca	ause(s) and manner	as stated.
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	(Check only Medical Examiner: On the basis of examinone) and manner stated.	nation and/or inv	vestigation, in my o	pinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
Vith Con	Ž	29b. Signature and title of certifier	W	29c. License			ed. Date signed (Mon 26	
•		30. Num and address of person who completed cause of death (Ite	-011		C 22 H	3	Mar, 26 10 2122	3
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Regist	rar	MAR 31 2010 Com	1. Au	ules				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 26, Physician/ John A. Chatham, Jr. March 2010 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Pickersgill Retirement Community Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
September 28,1923 New Jersev 1 ★ M 2 🗆 F Months Days Hours Min. 86 Director 154-18-4569 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Timonium 1 Yes 2 No Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country?
United States Funeral 240 Cinder Road 21093 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes. Give 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beer Distributor self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Chatham, Sr. Lillian Stilwill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Emma R. Chatham/ wife 240 Cinder Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State March 30, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Timonium, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. Timonium, 2325 York Road Maryland 21093 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onser and Death Kun Son Physician/ disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown been signed to should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670, N. Charle St. Balts. Md 21205 GAMIC

Registrar
DHMH 17 Rev 7/2009

State

. Date filed (Month, Day, Year)

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68760	eath certificate be e attending physicis	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy	-					23d. Date of	delive	rv
Box	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Funeral Director, After this certificate has been signed by the attending physicisted filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregna Other (specify)					Month		Day Year
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j	law rec has be	Completed								24a. Was auto	psy		to con	sy findings available pletion of cause of
a a	in: The ificate or, pag		25. Was case referred to medical		_		26	Place of De	eath (Check o	1 🗆 Yes	2 D			2 □ No
Vit.	ding Physician: The law h. After this certificate has funeral director, page 2	To Be	examiner? 1  Yes 2  No					thor:			dence	6 Other (Sp	ecify)	
2	ding P th. After t	cate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigatio	28a. Date of injui (Month, Day		28b. Time of injury		uryat ork? ☐ Yes 2 [	1	d. Describe h	now inju	iry occurred		
Division of Vital Becords	l or Attend after death Director; /	Certificate:	3 Suicide 6 Could not be determined	e Blace of Init						3f. Location (5 City or Tox		nd Number or	Rural I	Route Number,
ć	Hospital or Attendii 24 hours after death. Funeral Director; A eted filled in by the fu		29a. Certifier 1 X Certifying Phy	rsician: To the best of			occured at the tir	ne date and	d place and				etated	
	To the Hospital o within 24 hours af To the Funeral Di completed filled in	Medical	(Check 2 L Medical Exam	niner: On the basis of exercise Practioner: To the	xamination	and/or invest	tigation, in my opi	nion, death o the time, dat	occurred at the and place,	e time, date a and due to th	and plac	e, and due to the	ne caus	se(s) and manner stated.
-	To with		29b. Signature and title of certifier	m)/	b w	\	29c. Licer	se number	hasto	sc.	29d. D.	ate signed (Mo	onth, D	ay, Year)
0			30. Name and address of person who	completed cause of de	eath (Item		Print)	0/6	NIN'	1170011	100	wer,	<b>少</b> ク	1,0010
91			AEBORAH BULLO 31. Date filed (Month, Day, Year)	EK, M.A. 32. Registra	VA Signati				IRE S	ISTEM,	119	RAY POLI	V/	1111) 21408
	Sta Regist	ate rar	MAR 3	1 2010	S Signati	<b>A</b> .	park	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09848 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ PHILLIP FRANCIS CIEH 8:55 AM 2010 ARCL Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GLEH BURNIE BALTIHORE-WASHINGTON HEDICAL CENTER 13auus Azuud A If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2 ... F Hours (Month, Day, Year) an 19, 1960 New York Director 50 Jan 215-62-4549 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits Ħ 10c. City. Town or Location Director or 28a-f sh notified a 1 🗆 Yes 2 🔀 No Anne Arundel Maryland Millersville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 8245 Ahearn Drive 21108 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Tes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White er than "natur , the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Diagnostics Technician <u>Automobile</u> is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. မ Robert S. Czeh Constance A. Hanousek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Constance A. Czeh/mother 2921 N. Leisure World Blvd #223 Silver Spring,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/31/2010 Woodbine, Maryland 21. Signare of Funeral Service Lice ser Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Thomas uanito M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician SEPTIC SHOCK 2AU048 Medical resulting in death) Examiner STATUSTIAN JAMES 2 DOGUATUOS SPAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner SHONTAS ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ABJUAD DIATZAR that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month 4 Pregnant : 9 Unknown Pregnant at time of death Day Year signed by the a 1 ☐ Yes ≥ L g ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HODEKIN'S DISEBSE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an tor: After this certificate has the funeral director, page 2: performed? Yes 2 N Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ★ Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ... only one) the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) M. Love Brain Dea Crown Ho D0065±1A MARCH 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO JOSE GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161 31. Date filed (Month, Day, Year, State MAR 31 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Smíth Harper Dean, Jr.  $A^{M}$ 29, 2010 6:15 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6214 Collinsway Road Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 № M 2 □ F Months Days Hours Min. **Director** 217-26-1365 78 6/14/31 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 KNo MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? Funeral 6214 Collinsway Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify 3 Widowed 4 Divorced 1950-53 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item 100. Elementary/Secondary (0-12) College (1-4or 5+) 12 1 Mechanical Engineer <u>Maryland Cup Corp</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Smith Harper Dean Ellen Kinsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty Jane Dean / Wife 6214 Collinsway Road Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 4/1/10 Crownsville, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lie 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Ener the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) navea Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 31 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O3 スロック 2:15 AM atherine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death or Location of Death Examiner izabeth Ba timore Ursin 8. Date of Birth Month, Day, July 29, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Hours 90 <sup>v</sup>1919 Mary Land 212-12-1689 Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Examiner must be notified 1 🗌 Yes 2 🕅 No or 28a-f Maryland Anne Arundel Brooklyn 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 23a Funeral 21225 4137 Doris Avenue items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Wildowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be lined when the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur and the Madical." 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Sec. Admin. Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine A. Lanehart Joseph Klein Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4137 Doris Avenue, Baltimore, Maryland 21225 Jack E. Neill (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State March 30, 2010 Brooklyn Park, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fusion Service Licen 22. Name and Address of Facility McCully—Polyniak Funeral Hone P.A. 130 Fast Fort Avenue, Baltimore, Maryland 21230 23a. a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death i diate Cause (Final h sician/ ui\_ease or condition Medical sulting in death) Examiner ension Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical mon the Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' 2 🗌 No 1 Tes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 20/0 death (Item 23a) (Type, Print) Name and address of person who completed cause Bultimore 3320 Benson vehue Mina MAD 31. Date filed (Month, Day, Year) 32. Registrar's Sign

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U | U Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27 Pay March Caroline Patricia Erickson 20 jeg 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1838 Ralston Place Crofton <u>Anne</u> <u> Arundel</u> 8. Date of Birth (Month, Day, Yea April 20, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Country) England Director 265-21-3777 59 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
Health and Mental Hygiene.
To is marked other than "natural", or items 23a or 28a-f show ther traunatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State Funeral Director 1 Tes 2 No Anne Arundel Crofton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? **IJSA** 1838 Ralston Place 21114 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Williamson Gillis Joan Haslam 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1838 Ralston Place Crofton, MD 21114 Eric E. Erickson/Husband item 2 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 Department of I Important: If it any injury or o ō 4 Donation 5 Other (Specify) W. Arundel Crematory 03-30-2010 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home & Crematory 21. Sign Auro / uneral Servige License 1411 Annapolis Road Odenton, MD 2111 25a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Immediate Cause (Final disease or condition CA nset and Doth COLON Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 5 Other (specify) Year Pregnant at time of death Day Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available 24a. Was an performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending work M 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one To the nate and title of

State Registrar ne and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

EFENSE IT GAWAY

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Warren E. Evans 14:17 Medical 201 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balkmole Baltimole 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth
June 30, 1949 Funeral 1 🕅 M 2 🗆 F Hours Director 60 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits MD Baltimore 1 Tes 2x No Randallstown 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 4816 Old Court Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. unk 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2400 W. Belvedere Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Firer Service 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner men Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 X No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🔯 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Function

completed (Check 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Evans

Wassen.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ONDILA

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ 101	partment of Health and Me ertificate of Death		iene 2010	09853
	Discoveries?		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		John W. Ellison		March	22, 2010	2:20 AM M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Ft. Washington Hospital	4b. City, Town, or Location of Death Fort Washington		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Geo	place (State or Foreign
	Director		579-48-4566 <sup>1</sup> ₹ M 2□ F 77 Yrs.	Months   Days   Hours   Min.	(Month, Day, Dec 12,	Year) Cou	rgia
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
	faryla show	ō		ashington			1 □Yes 2√□No
	the N	rect	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Cou	21
	h with 23a or et be	a D	12021 Livingston Road	20744		USA	
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. that "natural", or items 23a or 28a-f show ent, the Madical Examinar must be notified at	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Amer Black, White,	
3-003p	urs aft al", or Exami	ρ	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 🛣 Divorced Year or Dates:	1 ☐Yes 2 No Specify:		Specify: b	lack
2	72 ho 'natur dical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working		16b. Kind of Business/Ir	ndustry
7	vithin sne. than	ldmi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		· ·	
7	filed v Hygie other i		17. Father's Name (First, Middle, Last)	banker  18. Mother's Name	(First, Middle, N	financi Maiden Surname)	unk
ומחמ	Ald be Aental rked c	To Be	John Ellison				dik
ary	2 shou and A is mai		19a. Informant's Name/Relationship (Type. Print)	ling Address (Street and Number or Rural	Route Number,	City or Town, State, Zi	p Code)
≥ ″	and stealth m 27		Christine Ellison/former spouse 760	Clairidge Lane Law	renceyi	11e, GA 30	046
Daltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examina must be notified at once.		4 Donation & 10 Other (Specify) 1 n at 5 to	position (Name of Da ernatory or other place)	ite 2	20c. Location - City or T	own, State
Dall	permit. Depart Import any Inj		21. Signature Fundal Service Licensee	22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120	1 <sub>1</sub> 655 W.	Baltimore	Street
n			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause or achiline.				Approximate Interval Between
~~; <b>F</b>	Physician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		resulting in death)  Due to((rras_consequence of):	Who Marine			
		ē	Sequentially list conditions, if any, leading to infinediate	Whe freumonia			
	cuted rd ansit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events				
,007	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
00	ficate physi s the t	edical	d				
XOO .	th certinate of the cer	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23d. Date of deli	
5	t the dea by the ar ached fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
<u>.</u>	es tha igned be del	by P	Part II. Other significent conditions contributing to deathful not resulting in the	underlying cause given in Part I.		pacco use contribute to	
cords,	requir	sted	THO XIC ORCEPTION )		1 ☐ Ye	s 2☑No 3□ Pro	bably 4 🗍 Unknown
ם ב	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed			24a. Was ar autops perforn 1 🗆 Yes 2	y prior to c	opsy findings available ompletion of cause of
ן מ	ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			
5 i	Phys r this ral dir	-: To	1 ☐ Yes 2 ☐ No			ence 6 Other (Spec	ify)
5	ding th. : Afte fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation		od. Besombe no	w mary occurred	
VISION	Atter er dea rector by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (St. City or Town	reet and Number or Ru.	ral Route Number,
5	ital or irs afte ral Dir lled in						
;	e Hosp 124 hou e Fune letely fi	edical	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, de: 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cand at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
1	vithir To th comp	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month	, Day, Year)
			Mann mo	00055120		March 23	2010
			30 Name and address of person who completed cause of death (Item 23a) (Type & March 23a)	mi SE Junte 310	Warks	ngha De	2003)
	Sta Registra		31. Date filed (Month, Day, Year)  MAR 3 1 2010  Area D. Jane	le l		V	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		tificate of E			Reg. No.	2010	09854	
	Physicia Medio		Decedent's Name (First, Middle, Last)     HARRY MICHAEL FRANZ					2. Date of De Month March		<sup>y</sup> 2010 Year	3. Time of Death 11:05A M	
	Examin		4a. Facility Name (if not institution, give s Gilchrist	treet and number)		4b. City, Town, or	Location of Death			County of Death  Baltimon		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In 71)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Pa	th y, <b>193</b> 8	9. Birtho	place (State or Foreign	
	f show	tor	Usual Residence of Decedent  10a. State  10b. County	10	c. City, Town or Loc	cation				1	0d. Inside City Limits	
	ne Mary or 28a-	Direc	Maryland None  10e. Street and Number		Baltimore	10f. Zip Code			10a Cit	izen of What Coun	1XX Yes 2 □ No	
	h with then s 23a comust be	neral	3331 Moravia Road			21214				USA		
3036	e filed within 72 hours after death with the Maryland tall Hyglene.  ad other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 XXMarried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces?  XX Yes 2 No If Yes, Give Year or Dates.	'ト/_'62	Vas Decedent of Hi Yes, specify Cuba		ecify Yes or No- Rican, etc.)		USA  14. Race - American Indian, Black, White, etc.  Specify: White ind of Business Industry  ectrical  Surname)  Town, State, Zip Code)		
Maryland 21215-0036	n 72 hou e. a <b>n "nat</b> Medica	mple	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give k	lent's Usual Occupa kind of work done d O NOT use retired)	ation luring most of work	ing	16b. Ki	ind of Business Inc	dustry	
21	ed withi Hygiene other th	Be Co	17. Father's Name (First, Middle, Last)	2	Elec	trician	18. Mother's Nam	o (Eirst Middle		ectrical		
ylan	ld be file Mental arked carked atic eve	힏	Harry James Franzoni					ise Fisch		Surriarriey		
, Mar	1 and 2 should be filed wit of Health and Mental Hygie item 27 is marked other other traumatic event, th		19a. Informant's Name/Relationship (Type Stephanie Peterson Fra			g Address <i>(Street a</i> <b>bravia Roa</b> d					Code)	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	more, Mary	land							
Balt	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service License									
F	Hysician .	Ø 13	23a, Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)		Interval Between Onset a Death							
- John	Medical Examiner											
1	red nsit	Examiner	Secus fially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):								
	be execu sician and burial-tra		that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):							
09/80 08/00	rtificate ing phy e as the	/Medical	IF FEMALE:									
, Box (	To the Hospital crattending Physician: The law requires that the death certificate be executed within 24 hours are death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1  Live Birth 2 4  Pregnant at tim 9  Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	y 			23d. Date of delive Month	ory Day Year	
as, r.c	quires that ten signed bould be deta	by	Part II. Other significant conditions con		ot resulting in the ur	nderlying cause giv	en in Part I.			se contribute to th	N 7	
Records,	The law re cate has be page 2 sh	Completed	7					24a. Was autor perfo 1  Yes	osy	prior to cor	osy findings available in pletion of cause of 2 No	
VITAI	sician: certific	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital:	2  ER/Outpatient	_ Othe	r:	, ,		M 041 (0	thenie	
on or v	ending Phy sath. nr After this	Certificate: T	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury work'	at	ome 5 □ Resid 28d. Describe h		Other (Specify) occurred	Labre	
DIVISION	talor Attersaler de rsaler de al Directo edilby t										Route Number,	
0	the Hospi in 24 hou the Funer	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	cian: To the best of my ker: On the basis of examiner: To the best	nation and/or investi	igation, in my opinio	n, death occurred a	t the time, date a	nd place,	and due to the cau	ise(s) and manner stated.	
\ 	Neitl To 1		29b. Signature and title of certifier	00 0	en D	29c. License	number		29d. Date	e signed (Month, E	Day, Year)	
	,		30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type, Pr				1-0			
	Stat	е	31. Date filed (Month, Day, Year)	32/Registrar's S	ignatule	· lows	ontown	Blud	10	m?us	40616 UM	
	Registra	ir	MAR 3 1 2010	Meur	p. papa	V						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of M		artment of Healt tificate of Deat			2011	09855
			Negistrar     Name (First, Midd)	de, Last)	001	timeate or Beat		2. Date of Death	g. No.	3. Time of Death
	Physicia Medio		Mary Catherine	Frye			I	March	26° 20°10	7:30 AM
	Examin		4a. Facility Name (if not institution The Villa	on, give street and number)		4b. City, Town, or Locat Baltimor			4c. County of Deat Baltimor	
. 1	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Un	nder 24 Hrs.	B. Date of Birth	g. Bir	thplace (State or Foreign
	Director		578-12-4862	1 □ M 2 <b>X</b> F	88 Yrs.	Months Days Hou	ars Min. J	une 2,	1921 Wast	ington, DC
	and show	ō	Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f ş otified	irect	Maryland Balt:	imore	Baltimo	re				1 ☐ Yes 2XX No
	with the s 23a or 2	<b>Funeral Director</b>	10e. Street and Number 6806 Bellona Av	ve.		10f. Zip Code 21212			g. Citizen of What Co Inited Sta	•
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 XX Never Married 2  Ma 3  Widowed 4  Divorce	If Yes, Give	No.	Vas Decedent of Hispanic i Yes, specify Cuban, Mex Yes 2X No Spe	kican, Puèrto Ri		14. Race - Ame Black, White Specify: wh	
Baltimore, Maryland 21215-0036	iin 72 hours ie. <b>han "natur</b> e Medical E	Completed	15. Deced	dent's Education hest grade completed)  College (1-4 or 5	(Give F 5+) life. DO	lent's Usual Occupation kind of work done during i O NOT use retired)	most of working	' M:	6b. Kind of Business ission Hel	Industry pers of the
121	ed with Hygier Ither ti	Be C	17. Father's Name (First, Middle,	5+	chur	ch ministry	4-41		acred Hear	t
lano	i be file fental i rked o tic eve	욘	John Frye	Lasty			lla Wats	First, Middle, Ma. SON	iden Surname)	
, Mary	d 2 should salth and M n 27 is ma er trauma		19a. Informant's Name/Relation: Sr. Loretta Cor			g Address (Street and Nu 001 W. Joppa		Route Number, C.		
imore	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other	n 3  Removal from State (Specify)		sition (Name of natory or other place) Lra1 Cemetery	Da Mar. 29		Oc. Location - City or Baltimore	Town, State , Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	tchill	Mi 165	Name and Address of Fa tchell-Wied 00 York Rd.	efeld F Balt	uneral I	Home Inc. MD 21212	
				or complications that caused tonly one cause on each line	d the death. Do not ente e.	r the mode of dying, such	h as cardiac or r	respiratory arrest	,	Approximate Interval Between
	Physician/ Medical	Ĥ	Immediate Cause (Final disease or condition resulting in death)	d	clerotic Ca	rdiovascula	r Disea	se		Onset and Death
	Examiner									
	ted d insit	Examiner	Sequentially list conditions, it any leading to the cause. Enter Underlying Cause (Disease or linjury	D. Due to (or as )	а оспянциною эff:					
0	icate be executed physician and s the burial-transit	edical Ex	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
876	tificate ng phy as the	Med	IF FEMALE:							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a g  Unknown	2 Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Division of Vital Records, P.O.	uires that th n signed by Ild be deta	by	Part II. Other significant condit	Jons contributing to death b	out not resulting in the u	nderlying cause given in F	Part I.		cco use contribute to	the cause of death?
Secord	he law req te has bee age 2 shou	Completed						24a. Was an autopsy performe	prior to d	copsy findings available completion of cause of
<u>a</u>	ysician; The la is certificate ha director, page	BeC	25. Was case referred to medical examiner?	2.9		26. Place of	Death (Check o		ΔINOI I □ Yes	2 🗆 No
Ξ	Physic this ce al dire	၉	1 ☐ Yes 2 X No  27. Manner of Death		ent 2 ER/Outpatien	t 3 DOA Other: 4			ce 6 Other (Spec	ffy)
0 0	nding I tth. : After e funer	cate	1 X Natural 5 ☐ Pend	28a. Date of inju ling (Month, Day tigation	ry 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2		d. Describe how	injury occurred	
Divisio	al or Attences after death	Certificate:	3 Suicide 6 Could	d not be	ury - At home, farm, stre	et, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
_	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2   Medical	ng Physician: To the best of Examiner: On the basis of early Nurse Practioner: To the	xamination and/or investi	igation, in my opinion, deat	th occurred at th	e time, date and p	place, and due to the o	ause(s) and manner stated.
	To the within 2 To the comple	_	29b. Signature and title of certifie	er		29c. License numb	er	3	Date signed (Month	, Day, Year)
			30. Name and address of person Tariq Mahmood,			stminster, N	MD 211	5.7		
	Stat	e	31. Date filed (Month, Day, Year) MAR 3 1		ar's Signature		.n/ 411.	, ,		
	Registra	4	111111 0 4 2							

Division of Vital Records, P.O. Box 68760,

		_			Indelible Inkapartment of I		•	_	
		1 - State Registrar			ertificate of		Re	g. No.	09856
Physic	ian	1. Decedent's Name (First, Middle,	,				2. Date of Death Month	Day 20/	3. Time of Death
/Medi Exami		Walter Frederic  4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death	<u> </u>	4c. County of De	0 3.45
<u> </u>		Franklin Squ	are Hosp	i+a1	Rose	dale		nore	
Funeral		5. Social Security Number 0	5. Sex 7. Ag 1X M 2 ☐ F	ge (In yrs. last birthd	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
Director		274-28-4693 Usual Residence of Decedent		76 Yrs			08/21/19	933   0	hio
show [at	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
or items 23a or 28a-f show	Director	MD Balti	more	Perry					1 □Yes 2√√ No
a or 2		10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
ms 23	Funeral	9824 Gunforge 1	12. Was Decedent		21128 3. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-	U.S.A. 14. Race - Ai	merican Indian,
or ite		1 ☐ Never Married 2 X Marrie	Armed Forces? d 1 X Yes 2 ☐ If Yes, Give	No Korean	If Yes, specify Cub  1 ☐ Yes 2 🛛 No	an, Mexican, Puerto	Rican, etc.)	Black, Wi	nite, etc.
ural",	d by	3 Widowed 4 Divorced	Year or Dates:	Iostilitie	s		T :		Mite
n "nat	plete	15. Decedent's (Specify only highest	grade completed)	(G	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of work		6b. Kind of Busines	ss/Industry
giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4or s	'	avel Consu	ıltant	s	tate of N	Maryland
Department of Health and Mental Highen. Including the Use of Health and Mental Highen. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examination in the Profiled at Once.	Be (	17. Father's Name (First, Middle, La	nst)			18. Mother's Name	e (First, Middle, M	aiden Surname)	_
narke natic	은	Walter L. Fisch					th Ann H		
Ith and		19a. Informant's Name/Relationship	, , ,		ailing Address (Street			•	
f Healitem other		Nancy C. Fischl 20a. Method of Disposition		20b. Place of Di	24 Guntore sposition (Name of strematory or other pla			LI, Mary I  Oc. Location - City	and 21128 or Town, State
nnt: If		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe			romatory	Tng 03/3	1/2010 B	altimore	Maryland
porta porta iy inju		21. Signature of Funeral Service Lie	censee	Metro C	22. Name and Addre	ess of Facility <b>E</b> .	F. Lassa	hn Funera	al Home, P.A.
20 E # 9		De Ala	assahrs		11750 Bela	ir Road -	Kingsvi	lle, Mary	land 21087
		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplications that caused ly one cause on each li	ne.		- 1			Approximate Interval Between Onset and Death
nysician Medical		disease or condition resulting in death)	aleft to	a consequence of):	empora	1 Her	norch	age	-
xaminer			Due to (or as	a consequence or,					
÷	je	Sequentially list conditions, in any, reducing to minimize date cause. Enter Underlying	D. Jue to (or as	a consequence of):					
and I-transit	xamine	Cause (Disease or injury that initiated events resulting in death) Last	c						
	ш	resulting in death, East	Due to (or as	a consequence of):					
g phys s the	edic		d						
attending physician for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		o∏5			23d. Date of	delivery
he att ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	<b>У</b>		Month	Day Year
d by t letach	Phy	9 ☐ Unknown  Part II. Other significant condition:		out not reculting in the	underlying source gir	on in Port f	23e Did tob	acco use contribute	to the cause of death?
signe d be d	۵	Hypostes Si			n, Diabe		1 ☐ Yes		Probably 4 Unknown
shoul	Completed	Mall'+446 Pa	cent Pate	+	11, DICO	Palal	24a. Was an		autopsy findings available
te has age 2	m d m	1"	2	A - 1	en ovare	. Katch,	autopsy perform	ed? prior to death	o completion of cause of ?
rtifica tor, p	Be	25. Was case referred to medical	scular	FICCIGI	ent	26. Place of Deatl			es 2 🗆 No
his ce		examiner? 1 ☐ Yes 2.★No		ent 2 🗆 ER/Outpa	tient 3 DOA Oth	ner: 4 🗆 Nursing Ho	me 5 ☐ Resider	nce 6 🗆 Other (S	pecify)
n. After t funera	ü	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ny, Year) Injur	y Wor	'k?	28d. Describe how	v injury occurred	
death ctor: y the 1	licat	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	be Ope Blees of Inc	ury - At home, farm,		Yes 2□No	28f Location (Str.	eet and Number or	Rural Route Number,
after I Dire	Certification: To	4 Homicide determine	building, et	c. (Specify)			City or Town,		, with route runner,
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria		(Check only 2 Medical Ex	Physician: To the best caminer: On the basis of	of examination and/o	eath occurred at the ti	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
ithin 2 o the I omplet	Medical	29b. Signature and title of certifier	and mariner sta	ated.	29c. Licens	se_number	29	d. Date signed (Mo	onth, Day, Year)
≥ ⊭ ८		1/2	Kerry	(may	Z	12871	/フー	_	2010
								1 7 / 0	

/) \ V

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Stephen Sclinger 9000 Franklin Square Baltimore, MD 21237

31. Date filed (Morth, Day, Year)

32. Registrar's Signature

withi To tl	0.0
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a v	
Sta	to ~

	_	Please Type or Print in Black Inde State of Maryland / Depart  1 - For State Registrar Certif		•	ne 2010	09857
Physicia /Medica		1. Decedent's Name (First, Middle, Last)  WILLIAM IGMATIUS GOVICER		2. Date of Death Month	Day Year 26 Zûlo	3. Time of Death
Examine		HOWARD LOUNTY GONDRAZ HOSPITAZ	b. City, Town, or Location of Death		4c. County of Deatl	
Funeral Director		215-26-8980 <sup>1</sup> ⅓½ <sup>2</sup> □ F 77 Yrs. <sup>1</sup>	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye NOV • 7 , 1	9. Birtl 932	nplace (State or Foreign untry) MD
th the Maryland or 28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Locat           MD         Anne Arundel         Laurel           10e. Street and Number         10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 □ No xx
after death w	by Funeral [	1 □ Never Married XXXX Married   12XX Ses 2 □ No 1.952	20724 s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto l	ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Ame Black, White  Specify: Wh:	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any Injury or other traumatic event, It is Medical Exp	Completed	(Specify only highest grade completed) (Give kin  Elementary/Secondary (0-12) College (1-4or 5+)	nt's Usual Occupation ad of work done during most of workin NOT use retired) er/Operator	ng S	b. Kind of Business/I State Farm Insurance	ı
Jould be file Mental Hy arked oth atic event	To Be	iden Surname)				
and 2 sho lealth and m 27 is m her traum		Karen Gouker / daughter 1420	Address (Street and Number or Rura Cavendish Drive	Silver S	Spring, MD	20905
Pages 1 tment of H tant: If ite jury or ot		20a. Method of Disposition  1 ★ Weurial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cremating Gate of H	leaven 3/31	/2010 Si	c. Location - City or Liver Spri	
permit Depar Impor any In once.		/ M00770	<del>/በጀ፤ሮያሪ</del> ሮ ምርዥሥታልl .3 Talbott Avenue	-		20707
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest	,	Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			-	30.445
be be	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. Swarzi CEU  Due to (or as a consequence of):	LUNG CANTER			Emintus
Attending Physician: The law requires that the death certificate roteath.  ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medica		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
quires that the de	þ	Part II. Other significant conditions contributing to death but not resulting in the under the light of the l	erlying cause given in Part I.			the cause of death?
The law requir cate has been s page 2 should	Completed	CARDISMY SPATITY NEUTROPENIA		24a. Was an autopsy performe	prior to	ntopsy findings available completion of cause of
ding Physician: The h. After this certificate h funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 Mo  Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death		ce 6 □Other (Spe	cify)
ending Ph eath. or; After th the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident Investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how		,
ital or urs afte ral Dir		4 Homicide determined building, etc. (Specify)		City or Town, S	-	
the Hosp Jin 24 hou the Fune Tipletely fi	ledical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or inversional manner stated.	stigation, in my opinion, death occurr	red at the time, date	e and place, an <b>d d</b> ue	e to the cause(s)
Co 7 with	≅	29b. Signature and title of certifier	29c. License number 0 36974		I. Date signed (Mont	
25x1			int) HZTSN DVZ SUITE	310 Cm	umain i	no 21074
Stat Registra	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature  MAR 3 1 2010 Server A.	west			
HMH 17 Rev 1/20	01	ORIGII				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Emma Gay Gamble 5:05 March 26, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Timonium Baltimore 13 Washington Street 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 11, 1933 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Virginia 216-28-0781 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Timonium 1 ☐ Yes 2X No **Funeral Director** Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 21093 13 Washington Street of America 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ŏ Specify: white If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Be Completed by 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker nt of Health and Mental Hyg :: If item 27 is marked other r or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Tennie M. Hushour Worley G. Frye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type. Print)
Mrs. Judy G. Irwin/ daughter 11617 Hunters Run Drive Cockeysville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20c. Location - City or Town, State 20a. Method of Disposition March 30, permit. Page: Department o Important: If i any injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Chapel- Bel Air 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. 21. Signature of Fugeral Service Licensee 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINUTES /Medical **Examiner** THERD SCLESCOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No of Vital 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes /2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53095 March 29, 7010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI) STATION CT #210 TIMONIUM, MARYLAND 21093 1 TEXAS 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

President   Pres	10-02224 UNK UNK	100	Please  1- For State Registrar	e Type or Print State of Mary	land / Depa		Health				egible	20	10	0985
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AND THE PROPERTY OF SECTION AN	Bal permit Depar Importinjury		21. Signature of Funeral S	Di ( ) . (	e feile								OL 171	10. 0.
Immediate Cause Final deease or condition resulting in death)   Deease or condition resulting in death   Deease or condition resulting in death   Deease or condition resulting in death   Due to (or as a consequence of):	Physician		23a, Part I. Enter the dise	ease, or complications that a cause on each line.	t caused the death	. Do not enter the	mode of d	lying, su	uch as cardiac	or respiratory	arrest, sh	ock, or hear	t Ar	etween Onset and
Sequentially list conditions, if any, leading to immediate the course of			Immediate Cause (Final o	disease a. <u>Intra</u>			ınd				_			Death
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29b. Signature and title of certifler  O.C.M.E.  March 20, 2010  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	executor an and al - tran	_	X UNPENDED	d. AMENDE	p		- 0/	20 /	/10/10					
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		_ For	State of M	larylan		artment of H			lental Hy	giene	0.0.1	0	00000
	1	State Registrar			Cer	tificate of	Death			Reg. No.	<u> </u>	U	03000
Physicia	ın	Decedent's Name (First, Middle, I	,	mh om s	e Huet	con, Sr.			2. Date of Dea	Day	- o	ear 010	3. Time of Death 10:56 AM
/Medic	210	4a. Facility Name (If not institution, g			is nust	4b. City, Town, or	r Location	of Death	Marc	4c.	County of	Death	10.361
Examine	ər	Laurel Region	1 11 1			1	urel			P	rinc	e (	George's
Funeral			Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day				ace (State or Foreign
Director		220-32-7079 Usual Residence of Decedent	1 XM 2 □ F	72	Yrs.				Feb 8,	193	8	Mary	yland
land ow	-	10a. State 10b. County		10c. City	, Town or Lo	cation						10	0d. Inside City Limits
a-f sh	ţò	MD Montgo	omery	Bur	tonsvi	ille							1 ☐ Yes 2 ☑ No
ith the or 28	Funeral Director	10e. Street and Number				10f. Zip Code					zen of Wha	at Count	try?
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ter de items	nu.	11. Marital Status  1 ☐ Never Married 2 ☒ Married	12. Was Deceden Armed Forces 1 □ Yes 2 X	?	5. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexica	n, Puerto	Rican, etc.)			White, 6	
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1□Yes 2ဩNo	Specify:	:			Specify: Wi	hite	<u> </u>
72 ho	Completed	15. Decedent's (Specify only highest of	Education grade completed)		I (Give	dent's Usual Occup	durina mos	st of work	ing	16b. Ki	nd of Busir	ness/Ind	ustry
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shou shou and M s mar umat	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Numb	er or Rur	al Route Numbe	er, City o	r Town, St	ate, Zip	Code)
ite, intally lail of LILID-0000 stand 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Bonnie J. Hustor	n / spouse			) McKnew	Road,						
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State		Place of Dispo emetery, crei	sition (Name of matory or other plac	ce)		Date	20c. Lo	cation - Ci	ty or To	wn, State
Deficiency of control	1	4 □ Donation 5 □ Other (Spe	cify)	Ft.		oln Cemet					ntwoo	d, N	Maryland
Dalti permit. Departr Importa any Inja		21. Signature of Funeral Service Lice	censee	M007	773   Î	2. Name and Addre Donaldson 313 Talbo	Fune	ral	Home, F	A. Mars	7land	207	07-4389
E G 13		23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cause								Tana	207	Approximate Interval Between
Physician	0.4	Immediate Cau Final disease or condition	R 13	red L	1 holans	and An	ctic	Ane	ritruem	١			Onset and Death 2 hours
/Medical		resulting in death)	a. Due o (or a	s a conseq	uence of):	inal Aoi Cardio	110	7.17.10	41 1311				- 110413
Examiner		Sequentially list conditions,	b. Arter	riosc	erotic	. Cardio	ovasc	cula	r Dis	eds	e		
bed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence or):								
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te be exysician	cal	,	d										
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ath cer ttendin or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 ☐ Feta	Ideath 3	Ectopic pregnanc	y:			1	23d. Date ( Montl		ery Day Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		leath 5L	Other (specify) _							
that the detacle	Ph.	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause giv	ven in Part	I.	23e. Did t	tobacco L	use contrib	ute to th	ne cause of death?
w requires to be a signer should be a	Completed by	Chronic Renal	Failure	,					1 🗆	Yes 2	□ No 3	☐ Prob	pably 4 □Unknown
law reas bee	plete	Coronary Arte	ery Disea	dse_					24a. Was		24b. We	ere auto	psy findings available mpletion of cause of
The The ate has page	E		/						perfo 1□ Yes	ormed? 2 No	de	ath? ∃Yes	2No
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Physi Physi rthis o	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Ir		ER/Outpatier	it 3 DOA		lursing Ho	ome 5 ☐ Resi 28d. Describe				у)
dlng th. : After e funer	tion	1 Natural 5 Pending 2 Accident investiga	(Month, E		Injury	Wo	rk? ]Yes 2∐	]No	Edd. Bodonbo	now myen	, 000000		
Atten er deat rector by the	ifica	3 Suicide 6 Could no 4 Homicide determin	20e. Place of I	njury - At he etc. (Specia	ome, farm, st	reet, factory, office			28f. Location ( City or To	Street an	nd Number	or Rura	al Route Number,
tal or rs after all Dir	Certification:	4		oto. (opcon					Ony or 10	,,, ,,			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical E	Physician: To the best kaminer: On the basis	of examina									
thin 2 the omple	Medical	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licens	se number			29d. Da	te signed	(Monthy	Day, Year)
F 3 F 8		17/2	112.0	7	644-	D	229	966	<b>6</b>	.7	121	-/	2010
·		30. Name and address of person w	ho completed cause of	death (Iter	n 23a) (Type,	Print) 73	00 Va	in Di	usen Ro	1.	Laure	21, N	VD 20707
dV			guieres, M		aurel	Region	al Ho	spita	al, Ema	2rge	ncy.	Dep	it.
Sta Registr		31. Date filed (Month, Day, Year)		strar's Signa	ature	-41		•	-	<b>\</b>	/	ł	
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DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryiand		rtment of F tificate of I			eg. No.2010	09861
	Physici /Medic		1. Decedent's Name (First, Middle, Last AWWA H (	RNE					2. Date of Dear Month MAR	Day 24 Year	3. Time of Death 10 1050 P M
	Examir		4a. Facility Name (If not institution, give	street and number)	C HO.	SPITAL	4b. City, Town, or	Location of Death		4c. County of Dea	ath
	Funeral Director		21/-26-0456	7. Age	(In yrs. las	t birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 22	Year) 9. Bi	irthplace (State or Foreign Country) aryland
	show show		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	Ba-f sh	ctor	MD Howard		Lau	ırel					1 □Yes 2 🙀 No
	ith the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	country?
	eath v	Funeral	9055 Dumhart Roa	d 12. Was Decedent Ev	er in IIS	12.1	2072		onify Voc or No	USA 14. Race - Am	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Every inc. (19st by Inclined at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			Yes, specify Cuba	Ispanic Origin? (Spo an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	lent's Usual Occup	ation during most of worki d)	ing	16b. Kind of Business	s/Industry
212	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, In. M.	omp	Elementary/Secondary (0-12)	College (1-4or 5+	)		omemaker	1)		Own Hon	10
	be filed Ital Hyg d other event,	BeC	17. Father's Name (First, Middle, Last)	ν			Zinemaret	18. Mother's Name	e (First, Middle, I		
ylai	ould b Ment arked aric e	2	Franz Gustav W				_	Margar	et Kroh		
Maryland	12 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (7)	,						r, City or Town, State,	Zip Code)
	s 1 and 2 f Health tem 27 I		James A. Horne/Hu 20a. Method of Disposition	sband	20b. Plac		Dumhart sition (Name of patory or other place	Road, Lau		20723 20c. Location - City o	r Town, State
Ë	Pages nent o int: If I		1 ☑ Buriat 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State				Pk 3/29/	2010	Elkridge,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licens	a nati	M0110	22	. Name and Addre		naldson	Funeral H	
	Physician	100	23a. Part 1 Er er the disease, or compi shoot, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	tation that caused the carse on each line	he death.	Do not ent					Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a	consequer	nce of):					
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequer	nce of):					
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequer	on off:					
68760,	ifficate be executed g physician and as the burial-transit	alE		Due to (or as a	consequer	100 01).					
.89	rtificat ng phy as the	Aedical	IE EENALE.								
.O. Box	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal de	eath 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
rds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but	not resultir	ng in the ur	derlying cause giv	en in Part I.			to the cause of death?  Probably 4  Unknown
of Vital Records,	: The law recate has being page 2 sho	Completed							24a. Was a autops perform	y prior to	
/ita	Physician: The this certificate ral director, pag	Be C	25. Was case referred to medical examiner?					26. Place of Death			- A.
of	Phys this ral dir	۲ <u>.</u>	1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatien 28a. Date of Injury		NOutpatien	t 3 DOA Oth	4 LI Nursing Ho		ence 6 Other (Sp ow injury occurred	pecify)
on	th. : After	ition	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		injury	Worl	Yes 2 □ No	zod. Describe no	ow injury occurred	
Division	Hospital or Attending P 24 hours after death. Funeral Director: After tely filled in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home (Specify)	e, farm, stre	eet, factory, office		28f. Location (Si City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or vaithin 24 hours after To the Funeral Direct	Medical (	29a. Certifier (Check only one) 1 ✓ Certifying Phy 2  Medical Exami	sician: To the best of ner: On the basis of and manner state	examination	edge, death n and/or in	occurred at the til vestigation, in my c	me, date and place, ppinion, death occur	and due to the cred at the time, d	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)
	vith:	Σ	29b. Signature and title of certifier				29c. Licens	e number 10 69 6 4 c		9d. Date signed (Mor	nth, Day, Year)
	3V		30. Name and eddress of person who co	SYED,	M.D	)	Print)	HIOH B		27,000	UMBIA, MA
	Sta Registr		31. Date filed (Month, Day, Year)	32. Angistrar			46				
	3.00		MAR 31 20	10 places	-		arts.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, 2010 ear MARCH HUBBARD THELMA 5:50 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death OAK CREST CARE CENTER BALTIMORE PARKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 □ M 2**X** F Months Days Hours 8/27/7973 MARYLAND 214-01-6978 96 Yrs. Director Usual Residence of Decedent 10a, State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE MD PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 WALTHER BLVD. APT. 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: WHITE 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. HOMEMAKER OWN HOME 12TH GRADE Be permit. Page 1 and 2 should be file. Department of Health and Mental Hy Important: If tem 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE EDWARD HARP LULA ERNEST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS W. BAUHAUS, JR./NEPHEW 312 GOLD BEUSIT WAY PASADENA, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/9/2010 PARKWOOD CEMETERY BALTIMORE. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MO0217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ ebiliti disease or condition resulting in death) Medical Due to (or as a co luence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months. Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimers Lementra Records, 1 Yes 1 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 2 🗌 No Yes 2 N 1 Tyes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Yes PNo 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Beath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. leaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Contifying Nurse Practioner To the Seet of my knowledge, death occurred at the time, debe and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifi Kalle R171944 msu ca ompleted cause of death (Item 23a) (Type, Print) ddress of person who o Carryon CKNP MSN B800 Walther Blvd, Parkville MD 21234

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u> Kar</u>Kuill Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day, Year) 16,1952 1 □ M 2 🛛 F Months Days Hours Min. Marylano 213-62-2751 Director 57 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director or 28a-f MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 2535 Hillcrest Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: white "natural", 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Baltimore City Public Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Dolores Dietrich William Herman Orzech, Jr and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl: Department of Health ar Important: If item 27 is any injury or other trau Alan Hunt, Sr-spouse 2535 Hillcrest Avenue-Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Gardens, of Faith
Cemetery Apr.1,2010 Rosedale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility l Chapel and Road-Parkvil Evans Funeral 8800 Harford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Medical P.O. Box 68760 the attending parties to the distribution of the art the distribution of the art the a IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: page 2 performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \mathbb{X} \) Residence \( 6 \) Other (Specify) 1 Tyes 2 🕅 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident 2 🗆 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar

Name and address of person

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

**ORIGINAL** 

who completed cause of death (Item 23a) (Type, Print) 92

Registrar's Signature

12 AM

timore

10d. Inside City Limits

Interval Between

Onset and Death

Day

Year

1 Yes 2 X No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 PeraAna BDryfand/ Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 3:17 PMM 7, 2010 March Dennis E. Harris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Riverdale 5538 60th Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number unk 6. Sex **Funeral** Days 1 € M 2 □ F Sept16, North Carolina 62 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County items 23a or 28a-f show Department of Health and Mental Hygiene. Important; if items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show important; if item 27 is marked other than appropriate Examiner must be realthed at once. 1 ☐ Yes 2 ☑ No Director Prince George's MD Riverdale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20737 5538 60th Avenue Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ∑Yes 2 □ No If Yes, Give Year or Dates: 163-11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify 163-67 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Henry Harris Jr Effie Mayo ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Harris/brother 14701 Berry Road Accokeek, MD 20607 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licensae Dan fel A. Naylor 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARGO VASCALAN HEART Atheroselerotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 T Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2-No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 🗌 Yes investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 3 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

Box 68760.

P.0.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20-45PM Sr Hornick. Medical Charles 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4b. City, 4c. County of Death Anny Baltimore-Washington Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🟋 M 2 🗆 F Months Days Hours Min. Nov. 18, 1929 WeSt Virginia Director 80 213-24-5653 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗗 No Anne Arundel Millersville Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21108 211 Obrecht Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces'

1 XYes 2 If Yes, Give
Year or Dates. Black White etc. ş 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", ied ... al Hygiene. ad other than "natural" the Medical E Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Academy N/A Machinist 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Department of Health and Merital Important: If item 27 is marked any injury or other traumatic evonce. ပ္ White Bessie Hornick Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Dogwood Road Millersville, Maryland 21108 Charles E. Hornick, Jr (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) ornick 04/01/2010 Marriottsville, MD Crestlawn Mem. Grds 21. Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) our runeral urector: After this certificate has been signed by the incompleted filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 700 1 🗌 Yes ည 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death of De atural Accident 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Purtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a title of certifi 29d. Date signed (Month) Day, Year) 8006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOF 01 31. Date filed (Month, Day, Registrar's Signa State 31 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Pearl V. Holmes 25 an Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death n/a Joseph Richie Hospic<u>e</u> Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Jan. 22, 1 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Min Months Days Hours **Director** 212-32-6588 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is and Mental thy than "natural", or items 23a or 28a-f show amy hijury or other traumatire event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1705 E. Eager Street Apt.404 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. Maryland 21215-00 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Public School Teacher's Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Ruff Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 E. Coldspring Lane Balto, Md. 21239 Bernice Bradley (niece) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Apr.1,2010 Park Balto,Md. nature of Funeral Service License 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1 1 1 2 F. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oeset and Death Immediate Cause (Final Ph, sician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specific 1 🗆 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Dea 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) gistrar's Signature State 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 10:28 AM 4b. City, Town, or Location of Death Examiner BaltiMore plar If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Hours 87-28 Director Usual Residence of Decedent 10d, Inside City Limits Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 XYes 2 ☐ No 10g. Citizen of What Country? 10e, Street and Numbe 21216 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give 3 

Midowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry conday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nar ဂ္ Kolwel Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) thod of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 Unior (Specify) Signature of Funeral Service Lig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final OLON months Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed; 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Hospital 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

CATON AV
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year EMMANUEL IROANYA 13:38 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MD UMMC BALTIMORE, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex Funeral 06 22 Min. 1 M 2 □ F Hours 53 610-32-7871 Yrs. Director Usual Residence of Decedent 28a-f shov 10a, State 10c City Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director Woodstock 1 Yes 2 X No Howard MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21163 Nigeria Tallowthree Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Therapist 5vrs+ 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mabel Nwokere John Iroanya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Tallowthree Road, Woodstock, Md 21163 Ifeoma Iroanya-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4/17/10 Abia State, Nigeria Ikwuano Umuahis 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, ala Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CARDIUMYOPATH disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law certificate has autonsy erformed? 1 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number P2308C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, Phe Greene St UMMC 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

## State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 4

Physicia	ın
/Medic	al
Examin	er

**Funeral** 

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f show or than "natural", or items 23a or 28a-f show or items 23a al Hygiene. other traumatic event, Health and Mental I em 27 is marked of

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

permit. Pages 1 Department of H Important: If ite any injury or ot

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours

Box 68760.

P.O.

Division of Vital Records.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, 2010 Year DOROTHY PAULINE JENKINS 7:30 p M March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Patuxent River Health & Rehab. Laurel Prince George's 8. Date of Birth (Month, Day, NOV 21, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 □ M 2 □ X Days Hours Min. Year) 1912 97 220-09-6309 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14709 Bowie Road, Apt. 203 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ∐Yes 2∭2No Specify: Completed by Specify: White 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 11 Bookkeepr Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Mitchell Ruth Hammond ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Baker daughter 14709 Bowie Road, Apt. 203 Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Yemation 3 ☐ Removal from State West Arundel Crem. 3/30/2010 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. (0 M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a, Part 1, Enter the disea Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzhiemer's Disease over 5 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arterio Sclerotic Cardio Vascular Disease 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗓 🖔 1 □ Yes 1 🗌 Yes 2 **X**X 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 XXXursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Iniury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 11/4-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 March 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Road, suite 208 Laurel, Maryland Syed Sadiq, M.D. 20708 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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	Bal	permit. Page 1 Department of Important: If i any injury or c		21. Signature of Fur	eral Service I	icensee	11	./		22. Name	and Addres	ss of Facility I West	:	_ "					
				23a. Part 1. Enter t	he disease, or	complicati	ions that cau	sed the deat				sh Av				ce,		L215 Approximate	
		Pnysician/		shock, or hear Immediate Cause (l	rt failure. List o Final	only one ca	use on each	line.	1	1	~	1		1	115	100		Interval Between Onset and Death	
(		Medical		disease or condition resulting in death)	n	a		as a consequ		no tic	400	9000	SCV	JON 1	112	K()			-
		Examiner	_	Sequentially list cor	nditions.	b. <b>–</b>											- 1		
	al al	sit s	Examiner	if any, leading to in cause. Enter Under Cause (Disease or i	rlying		Due to (or	as a consequ	ience of):										
	1	xecuted n and al-transi	Exa	that initiated events resulting in death) L	3	c. <b>_</b>	Due to (or	as a consequ	uence of):								-+		
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	Box 68760	tificat ng ph as th	Mec	IF FEMALE:		1													
	9 X 6	th cer ttendi	ian/	23b. Was decedent in the past 12 r		1	If yes, outcor	th 2 🗌 Feta	death			У			1	23d. Dat	e of deliver	y Day Year	
	ĕ.	ne dea / the a ched f	nysic	in the past 12 n 1 ☐ Yes 2 <b>5</b> 9 ☐ Unknown	No		4 ☐ Pregnar 9 ☐ Unknow		ieath	5 Other	(specity)					IVIO		Jay Teal	
	P.O.	v requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medical	Part II. Other signifi	icant condition	ons contrib	uting to deat	h but not res	ulting in th	ne underlyin	g cause giv	en in Part I.		23e. Did t	obacco	use contri	ibute to the	cause of death?	
	ds,	equires een siç ould b	ted					_					-	1 🗆	Yes 2	No No	3 Proba	ıbly 4 X Unkno	wn
	SCO	law re has be e 2 sh	mple											24a. Was auto		P	Vere autops prior to com leath?	sy findings availab pletion of cause o	le of
	E E	sician: The law r s certificate has b lirector, page 2 sl		25. Was case referre	ed to medical									1 🗌 Yes			Yes 2	<b>X</b> No	
	/ita	siciar s certii lirecto	To Be	examiner?		Hosp	ital:	atient 2 🗆	FB/Outon	tions 2 🗆	Othe	ace of Death	,				(0)	<u> </u>	
	Division of Vital Records,	<b>ling Physician:</b> The le h. After this certificate ha funeral director, page		27. Manner of Death			8a. Date of it		28b. Time	e of	28c. Injury work	y at	$\overline{}$	5 Resid. Describe I					
	sion	I or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident 3 Suicide	Investiç 6 🗆 Could	pation not be	8e. Place of	Injuny - At ho	me farm	M street facto		Yes 2 N		E Loostian /	Ptmot or	ad Mumba	r or Rumi F	oute Number,	
$\sim$	Divi	tal or A rs after al Dire ed in b		4  Homicide	determ	ined	building,	etc. (Specify,	)		ory, omco		20	City or Tov			r Or Hurair	oute Namber,	
	4	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burians.	Medical	(Check 2 only one) 3	☐ Certifying	xaminer: 0	on the basis o	f examination	and/or in	vestigation,	in my opinio		urred at the	e time, date a	and place	e, and due	to the caus	e(s) and manner st	ated.
4		vitt To		29b. Signature and	and the	M	1/0	out.	1	2	9c. License	number	7		29d. Da	ate signed	(Month, Da	ay, Year)	
				36. Name and addre	Mil:	who comple	eted cause o	f death (Item	23a) (Typ	e, Print)	4.11	CT 11	- La	://_	14	d 2	109	5 f	
		Stat Registra		31. Date filed (Month	1 2010	Ben	32. Regis	strar's Signat	back	1		<u> </u>			1			<i>y</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 3 Year 04:25 AM 29 2010 Mary Anne Kanis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GOUD SAMARITAN HUSP ITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months 219-12-7946 Director 13, 1925 Feb. Pennsylvania Usual Residence of Decedent a-f show lifted at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8018 Dalesford Road 21234 U.S.A. ころう 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Be Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Ŧ. College (1-4or 5+) 10 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) , P73823816 95 F Stephen ٩ Plasa i Helen Bankovic 19a. Informant's Name/Relationship (Type. Print) (daughteri) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 5822 York Road Baltimore, Maryland 21212 Department of Hash Important: if Item 2 any injury or other once. Sr. Sharon Kanis, S.S.N.D. Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. 3-31-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Mitchell—Wiedefeld Funeral 6500 York Road Baltimore, 23a. Part 1. Either the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstructive Pulmonoury Discose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) n signed by the a ld be detached for 1∐Yes 2√ZNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown onenar Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 2 No 1 □ Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ္ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation ieral Director: / filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier f☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Alsynotol

State Registrar

ABHIJEET GHATOI . 5601 Loch Rowen 31. Date filed (Month, Day, Year) MAR 31 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MID

RES- DOD

03/29/2010

Blud. Boutimore TXD - 21239

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lynn Wallace Kirk 9:38 March 17 2010 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11 W. 20th Street; Apt 2E Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Days Months unk 238-96-0846 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 W. 20th STreet #2E 21218 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 🔼 No 1 Never Married 2 Married 1 □Yes 2√√ No If Yes, Give Year or Dates: Specify Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Baltimore City Police Dept 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation /5\Other (Specify) in state 21. Signature of Fun ral Service License 22. Name and Address of Facility Tor State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 16 moul disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2/2 No 1 ☐ Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

attending physician and for use as the burial-tran

has

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

an "natural", or items 23a or 28a-f show

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f Health and Mental Hygien tem 27 is marked other the other traumatic event, Inc.

Department of Health Important: If item 27 any injury or other troonce.

Director

Funeral

<u>გ</u>

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

altimore,

Examiner Physician/Medical been signed by the should be detached þ Completed page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be Certification: To

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation 2 Accident

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifie

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year) 231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wavis 3333 R

State Registrar 31. Date filed (Month, Day, Year) MAR

3 Suicide

29a, Certifier

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 450 A M 2. Date of Death Physician/ Month 2010 ALLENELEGGETTE Medical 4a. Facility Name (if nqt,institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ditizens Nursing Home avie De Groce Hartord 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min Director MISSISSIPPI 220-22-2052 SEPT 1917Usual Residence of Decedent aţ 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 ☐ Yes 🏋 No MARYLAND HARFORD CO HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 MARKET STREET 21078 U.S.A. "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: BLACK item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12yrs 6<u>yrs</u> TEACHER I.T. MONTGOMERY SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ DAVID E. ROBINSON t. Page 1 and 2 should be thent of Health and Mertant: If item 27 is mark JULIA BAGGETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Leggette James/DAughter 3601 Tindall Ct., Fayetteville, N.C., 28311 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Dongtion 5 Other (Specify) GARDEN MEMORIA PARK 04-03-10 JACKSON, MISSISSIPPI Signatur of Funeral Service Liver 22. Name and Address of Facility
WILLIAM C BROWN COMM
321 S PHILADELPHIA I FUNERAL HOME-HARFORD, P.A. BLVD., ABERDEEN, MD 21001 Þ caused to e ch line. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death rangs Physician 915045 disease or condition resulting in death) Medical Due to Lr as a consequence of) Examiner MMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami signed by the attending physician and deed be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 400 1 Tes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) of Vital Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at injury Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) m. 1) SIM 3 29 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21078 Mit

Registrar

DHMH 17 Rev 7/2009

State

31 Date filed Month, Day, Year) MAR 31 2010

eddethe,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:40 March 21 2010 Lederman Strouse Nancy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Manor Care If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 □ M 2√ F New York 1917 27. 93 Jan. 054-07-7476 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a, State 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment is until the notified at 1 ☐ Yes 2 ☐ No Directo Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 440 Westshire Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ⋧ 3 XWidowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Maryland al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12 <u>Receptionist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ould be fi Mental I of Health and Menta item 27 is marked Cogliano Angelo Dora Drasner ို Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3036 Seneca Chief Trail, Ellicott City, MD 21042

ce of Disposition (Name of Date 20c. Location - City or Town, State Rosalie Hunt (Daughter) other 1 20b. Place of Disposition (Name of 20a. Method of Disposition Baîtimore Crematory
@ Loudon Park ŏ permit. Page Department o Important: If a 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/29/10 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part L Em. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) day S **Physician** Advance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical ending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No atten for us 3 Fctopic pregnancy Year Month 5 Other (specify) Ö s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? Yes 2 No has e 2 s page 1 🗆 Yes After this certificate Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Hospital 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred filled in by the funeral Injury at Work? 27. Manner of Death 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) of death (Item 23a) Pype, Print)
10 8415 Bellong Lane #216, TOWSON who completed cause 50 132. 31. Date filed (Mont) Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	— Claic of W	ai yiai i		tificate of l			Reg. No.	10	09875
	Physicia	an/	1. Decedent's Name (First, Middle, La	•					2. Date of De Month		Year	3. Time of Death
1000	Medio Examir		Tessie A.  4a. Facility Name (if not institution, given	McCaule e street and number)	<u>y</u>		4b. City, Town, o	r Location of Dea	<u> March</u>		2010 ty of Death	1:10 A <sup>M</sup>
1	f		Gilchrist Hospice				Towson	•			timore	
	Funeral Director		577-40-6702	1 □ M 2 □ <b>X</b> ⊏ I	e (In yrs. Ia <mark>80</mark>	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year) 1929	Count	place (State or Foreign try) <b>gînia</b>
	and show	ō	Usual Residence of Decedent  10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City	, Town or Lo	cation	_			10	0d. Inside City Limits
	Maryl 28a-f	Director	Maryland Baltin	ore	То	wson						1 🗆 Yes 2 🔀 No
	vith the 23a or st be r		10e. Street and Number  555 West Towson	town Blyd			10f. Zip Code			10g. Citizen of USA	What Coun	try?
	death v items ier mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-		ce - America	an Indian,
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No		Yes 2 X No		to Rican, etc.)	Bla Specify	ack, White, e /:	utc. White
15-(	72 ho in "nat Medica	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give I	lent's Usual Occup kind of work done of ONOT use retired)	ation during most of wo	rking	16b. Kind of E	Business Ind	ustry
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and	ntal Hy ced ott	To Be	17. Father's Name (First, Middle, Last)  John Henry Stru	n k					me (First, Middle,		,	
aryl	hould tund Me s mark umatin		19a. Informant's Name/Relationship (		_	19b. Mailin	g Address (Street a		a Madele			ode)
Σ	ind 2 s fealth a im 27 i		Louis W. McCaul	ey/Son								and 21042
Baltimore, Maryland 21215-0036	Page 1 and the page 1		20a. Method of Disposition 1 □ Weurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	ce	metery, crem	sition (Name of natory or other place <b>emorial</b>		Date 7/2010	20c. Location	•	
Balti	permit. I Departri Importa any inju		21. Signa a f Funeral Service Licer		Dow	ner 22	Name and Addres	ss of Facility	loney &	King F	unera	Home, In
			23a. Part 1. Inter the disease, or con shock, or heart failure. List only	plications that caused	the death.							Approximate
- +	hysician/ Medical	e i	Immediate Cause (Final disease or condition resulting in death)	a. Bree	5+	Car	cel				- 1	Interval Between Onset and Death
	Examiner		resulting in death)	Due to (or as a	conseque	ence of):				_		
	D #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	ence of):						
	xecuter and	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):					-	
00	tificate be executed ng physician and as the burial-transit	Medical		l d								
68760	# <u>2</u>		IF FEMALE:	23c. If yes, outcome of	of pregnan	CV	_					
Вох	f f f	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 N No 9  Unknown		2 🗌 Fetal	death 3 🗌	Ectopic pregnanc Other (specify)	у			nte of deliver onth [	ry Day Year
P. 0.	v requires that the dea been signed by the s should be detached	by Ph	Part II. Other significant conditions of	ontributing to death bu	ıt not resul	ting in the ur	nderlying cause glv	en in Part I.	23e. Did to	bacco use cont	ribute to the	cause of death?
	σ 50 A						,		1 □ Y	es 2□No	3 🗌 Proba	ably 🏰 Unknown
200€	lay	Completed							24a. Was a	sy	prior to com	sy findings available inpletion of cause of
ř =	Physician: The this certificate heral director, page		25. Was case referred to medical		_		26 Dia	ice of Death (Che	1 🗆 Yes		death? 1  Yes 2	? □ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nysicia nis cer I direct	2 B	examiner? 1  Yes 2 No	Hospital:	nt 2 🗆 E	R/Outpatient	Otho		ome 5 Reside	ence 6 1 Oth	er (Specify)	hospics.
Division of Vital Records,	nding Physician: Tth. This certification of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director, property of the director of		27. Manner of Death  1  Natural 5 □ Pending	28a. Date of injury (Month, Day,		8b. Time of injury	28c. Injury work	at ?	28d. Describe ho			
ISIO	Attender of the state of the st	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injur		ie, farm, stre		Yes 2 ☐ No	28f, Location (St	reet and Numbe	er or Rural R	Route Number
_ ≥	urs afte			building, etc.					City or Towr	n, State)		
=	Io the Hospital or Attending Pl within 24 hours after death. To the Funeral Director. After it completed filled in by the funeral	Medical	(Uneck 2 L Medical Exam	sician: To the best of n iner: On the basis of ex se Practioner: To the b	amination a	and/or investi	ration, in my opinio	<ol> <li>death occurred :</li> </ol>	at the time date an	d place and due	a to the cause	va(c) and mannor stated
Ė	Vithin Vithin Comp		29b. Signature and title of certifier	se Fractioner. 10 the p	est of fily k	rnowledge, de	29c. License			cause(s) and ma		
			Allan	Cun			DS	830	3 in	Melt 2	y 2	olo
5	<b>√</b>			completed cause of dea	ath (Item 2	3a) (Type, Pr	N. Cu	renles	Sr ton	VSON	M	
	State Registra	e i	31. Date filed (Marth, Ray Year) 201	3 Registrar	's Signatu	Long	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 09876

		1- For State Registrar				Cer	rtificate o	f Death				Reg.	. No.		
Physicia		1. Decedent's Nam									2. Date Mon	of Death	Day Year		3. Time of Death
Medical Exami	ner		ey Ja:								Mar	ch 24, 2	010		0915 hrs
		4a. Facility Name (		on, give stre	et and num	ber)		4b. City, Tow		ocation of De	ath		4c. County of	Death	1
								Edgewo					Harford		
Funeral Director		5. Social Security I		6. Sex		Age (In yrs. la		If Under 1 Months	Year Days	If Under 24H Hours M	Hrs. 8. Da Min. T.:	te of Birth(	(MM/DD/YYYY)	<ol><li>Bird</li><li>Foreign</li></ol>	thplace (State or
Director		217-16-	4429	1 M	2 <b>4</b> F		86 <sub>Yrs</sub>		Dayo	, would		#111. I	2,1924	Co	Maryland
ž.		Usual Residence o	f Decedent 10b. County			Idon City	T							$\equiv$	
ow any		MD	Tob. County	Harfo	bro	Toc. City,	Town or Locat	ion Igewood	F						10d. Inside City Limits
Maryland 28a-f show	ţō											<del>,</del> _			1 Yes 2 No
5-0036  ed within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	10e. Street and Nu 13 Reeds		<b>5</b> c c (				10f. Zip Co				10g.	. Citizen of Wha	t Cour	ntry?
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hour "nate	Completed	15. Decedent's Ed			College (1-4		16a. Deceden during m	rs Usual Occ ost of working				e  10	6b. Kind of Busi	ness/li	ndustry
36 nin 72 than dical	읣	6	Jildai y (0-12)	,	ollege (1-4	UI ST)	Assem	bly Li	ne I	Worker			Bendix	ζ	
21215-003 uld be filed withi mental Hygiene, marked other to event, the Med	Ē	17. Father's Name	(First Middle	Last)	-		-		118	Mother's Na	me (First M	iddle Mai	den Surname)		
215 e file tal Hy ed o	Be		Lee (	,	s Tri	mble			1.0		l Bus		den Sumame)		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	2	19a. Informant's Na					19b. Mailing	Address (S	Street a				er, City or Town,	State	Zip Code)
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Dep Dem Diju	ł	andon	Lor	754	10					,	apel.	and, Ç	rematic	n S	ervices
Physician	1	23a. Part I. Enter th	e disease, or	complicatio	ns that caus	ed the death.	Do not enter th	e mode of dy	ing, su	ch as cardiac	or respirat	ory arrest,	shock, or heart	anc	Approximate Interval
/Medi_J	- 1	failure. List onl					-l	1 4 - 4			1	داد مدم		9	Between Onset and Death
Examiner	-	Immediate Cause ( or condition resulting				nsequence of	herosc	Teroci	e e	ardiov	ascui	ar u	Isease		
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Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certify hours after death. Funeral Director: After this certificate has been signed by the attending till fell in by the funeral director, page 2 should be detached for use a							, disea		se give	n in Part I.	236.				he cause of death?
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Sior Attend or death. rector: by the	ä	2 Accident	5 Pend Inves	ing tigation				1	Yes	2 No					
ivis after dinb.	<b>≌</b>	3 Suicide		not be	Be. Place of	Injury - At hor	ne, farm, street	, factory, offic	e build	ling, etc.		ition (Stree		r Rura	al Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide	deter	mined (	Specify)							oun, out	,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month **Physician** 4:20 AM Stanley Nierwienski March 21, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Elkton Care & Rehab Center Ceci1 Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 2, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1**∑** M 2□ F Maryland Director 85 218**-**14-6236 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2√ No Director Elkton MDCecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21921 Price Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Specify: White 1 ☐Yes 2X No Specify. \$ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) O water treatment plant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Nierwienski Mary Gabrowski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Mary Robin Taylor/friend 95 N. Riverton Road Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation ∫ 5 ☐ Other (Specify) Tanici A. Na lor 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Jementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, Division of Vital Records, P.O.

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

t 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 00023322 29b. Signature and title of certifier acholen SMT

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, S. S. SACHDEV MD 126A EHEL Elhan MD2/92/ SACHDEN MD

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Division of Vital Records, P.O. Box 68760,

	-	For State Registrar			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cert	ificate	of D		2110 11	iornar i ij	Reg. No	211	0	09878	3
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Physicia /Medica		Kenneth	Lee Ow	ens								March			Year ) 1 0	8:30 A M	
Examine		4a. Facility Name (	If not institution	give street and n	umber)			4b. City, To			of Death		4c.	. County o	f Death		
				St.; Ap					ber1					Alle <sub>g</sub>			
Funeral Director		5. Social Security N 230-54-4	4223	6. Sex 1 X M 2 □ F	7. Age (I.	n yrs. last bir 69		If Under 1 Months	Year Days	Hours	24 Hrs. Min.	8. Date of Bi (Month, D Apr 3	$\stackrel{rth}{0}, \stackrel{Year}{1}$	940	9. Birthp Coun Miss	lace (State or Foreign try) Souri	1
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perm Depa Impo any i		21. Signature of	Janiel A	Naylor	1.			täte altimo				d 655 T	W. Ba	altim	ore	Street	
		23a. Part 1. Enter shock, or he	the disease, or art failure. List	complications that	caused the	e death. Do	not enter	r the mode	of dying	, such as	cardiac	or respiratory	arrest,			Approximate Interval Between	
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nding Ph ath. r: After th e funeral	ation:	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	ath 5 ☐ Pending investig	(Mo	e of Injury nth, Day, Yo		Time of Injury	286 M	c. Injury Work?			28d. Describe			• •		
il or Atte after dea Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ⊡Could n determi	nod   286. Plac	e of Injury ding, etc. (	- At home, fa Specify)	arm, stree	et, factory, o	office				(Street a		r or Rura	I Route Number,	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, parts of the funeral director director, parts of the funeral director, parts of the funeral director, parts of the funeral director director, parts of the funeral director, parts of the funeral director director director, parts of the funeral director directo	ledical C	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physicien: To the Examiner: On the and ma	ne best of n basis of ex	camination ar	e, death nd/or inve	occurred at estigation, i	t the time	e, date ar	nd place, ath occur	and due to th	e cause(s e, date an	s) and mai d place, a	nner as s	stated. o the cause(s)	
Fo the vithin Fo the comple	Me	29b. Signature and	d title of certifier					29c.	License	number			29d. Da	ate signed	(Month,	Day, Year)	
->-		<b>•</b>	grale		N				D 6	017	565		m	n. 2	5,2	1010	
		30. Name and add	iress of person of 732117ho	who completed car		th (Item 23a)	4		4	20	١١٠	, 10	) ,	2150	2		
Stat Registra		31. Date filed (Mor	nth, Day, Year)		Registrar's	Signature	1							,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28, MICHAEL J. PHILLIPS MARCH 2010 2:20 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min. MARYLAND Director Yrs 219**-**58-0300 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD BALTIMORE 1 Yes 2 No TOWSON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 WATERWAY COURT APT. 2B 21286 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □ XYes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married 5-0036 If Yes, Give Year or Date Vietnam 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced "natural" Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Baltimore, Maryland 2121 Elementary/Seconday (0-12)

11TH GRADE College (1-4 or 5+) DRIVER IRON MOUNTAIN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname BENJAMIN PHILLIPS MARGARET NEWCOMB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE L. PHILLIPS/WIFE 4 WATERWAY CT. APT. 2B TOWSON, MD Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State DUCANEY "VALLEY" MEM 4 ☐ Donation 5 ☐ Other (Specify) 4/1/2010 COCKEYSVILLE, MD **GARDENS** 21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. 22. Name and Address of Facility MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ordenceducino ocomber 20 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). signed by the attending physician and does detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by COLOUOUN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 performed? Yes 2 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 × No Hospital: Other: မ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pendina Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature nd title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enocce

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

182/8

32. Registrar/s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 26, 2010 ar 9:00 P M ter 9 lorino /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1 M 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Months Min. Hours a Yrs. 114-07-8132 Director Herkimer, NU Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Lineits Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evandor trust be notified a once. 1 ☐ Yes 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 21120 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 In Yes 2 ☐ No 11. Marital Status Race - American Indian. 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: 2 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Dloyed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ance Mosina 19a. Informant's Name/Relationship (Type. F) 19b. Mailing Address (Street and Number or Rural Route Mymber, City or Town, State, Zip Code) Pe Vivian 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State Valley Mem. Gardens 4 Donation 5 □Other (Specify) 10 limonium and Address of Facility 14924 YORK Kd., THONK TON MD 21111 21. Signature of Funeral Service Licensee Evans Funcial Chapel + CREmation SERVICES Monkeyon NOUR or committations that caused the plath. Do not enter the mode of dying, such as cardiac of respiratory arrest, list only the druse on each in-23a. Par 1. Enter the diseas-shock, or heart ailure. Immediate Cause (Fina ASDIVA Physician 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Vasculor 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed acten 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate has congestive perform renai fain 1 ☐ Yes 2 1 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 [[Natural 5 Pending investigation death. spital or Attendliours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number · Cyntina Smaen D0051347 3/27/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Baltimore MD 31. Date filed (Month, Day, Year) 32. Regi trar's Signature State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend Items 23a per dr., g901,03/31/2010dnb Ensure All Copies Are Legible.

Amend Items 23a per dr., g901,03/31/2010dnb and Mental Hygiene 2 0 | 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ Month Sarah Elizabeth Reed 7:30 B Mar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4106 Kennygreen Ct. Randallstown Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours Days 1 🗆 M 2 🗆 Country) Director 213 28 0471 Yrs. 81 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD ☐ Yes 2 ☐ No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4106 Kennygreen Ct. 21133 USA "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian ě, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black If Yes. Give 3 Widowed 4 ☐ Divorced Completed Year or Dates. er than "natur , the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife Home marked other tumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Bailey Ella Sample 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karolyn Banks (daughter) 4106 Kennygreen Ct. Randallstown, Md. item 2 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Date ty Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Ponation 5 Other (Specify) King Memorial Pk. Mar. 23, 20 10 Balto, Md. ature of Funeral Service Licensee 22. Name and Address of Facility B. Scruggs Funeral Home Preston St. 21213 to Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between 0 Diabetes Mellitus WeeksDeath Immediate Cause (Final Ph sician/ - Acute Rena1 Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Renal Failure Years Sequentially list conditions, Examine Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Type 2 Diabetes Mellitus To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? cate has been signed by the atter page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2/10 RIO Hospital Other: 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify, 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 1 Yes 2 No Accident Investigation after death Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and other of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

		-	For State Registrar	15223	e anale	state of	Marylar	ia, Dopi	ai tiric	ent of F ete of E	ioditi i di	nd M	ioritai i iy	giene Reg. No.	201		9883	
	Physicia Medic		Decedent's Nam     Vernon										2. Date of De Month 03		,	Year 2010	3. Time of 9:15	
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	Funeral Director		5. Social Security N 213–20–0	umber	6. Sex		_	last birthday) Yrs.		ler 1 Year	If Under 24		8. Date of Bir (Month, Da 09/24/	th	liai	9. Birth	nplace (State or ntry) yland	r Foreign
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within 72 hours after death with the Maryland	ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1  Never Marr 3  Widowed		ried	Was Deceden Armed Forces 1 X Yes 2 I If Yes, Give Year or Dates	? No		f Yes, sp	edent of Hi ecify Cuba 2 🛣 No	n, Mexican, P	? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Rac	e - Ameri k, White,	ican Indian, , etc.	
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and 2 sh	Health ar em 27 is ther trau		Peggy K		,	ahter)							Route Numbe	. ,			85-1112	>
-			20a. Method of Disp 1 X Burial 2 4 Donation	☐ Cremation	3 🗆 Rem	100	te (	Place of Dispo cemetery, cren	sition (Na natory or	ame of other plac	e)	D	ate	20c. Lo	cation -	City or T	own, State	
ermit. P	Department of Important; If any Injury or once.		21. Signature of Fu			0 (	FOL	22	2. Name	and Addres	s of Facility	c. F		ahn 1	Fune	ral	and Home, 1 and 21	
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death certificate be		Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	pregnant months?		If yes, outcom    Live Birth   Pregnant   Unknown	ne of pregna	ancy	Ectopio	c pregnanc	у				23d. Daí	te of deliv	,	'ear
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Physician:	th. After this certificate funeral director, pag	To Be	25. Was case referred examiner?  1  Yes 2	ed to medical	Hosp	ital: 1 ☐ Inpa	atient 2	ER/Outpatier	nt 3 🗆 I	Othe	ace of Death (	_		dence 6	Othe	Assis	$_{ t Liv}$	
g	eath. <b>or;</b> After th the funeral	Certificate:	27. Manner of Deatl  1 □ Natural 2 □ Accident 3 □ Suicide	h 5 ☐ Pendir Investiç 6 ☐ Could	g pation	28a. Date of in (Month, E	ijury Day, Year)	28b. Time of injury	М	28c. Injury work' 1 🗆	at	2	8d. Describe h					
Hospital or Attending	within 24 hours after death.  To the Funeral Director: Af completed filled in by the fu		4  Homicide	determ	ined 2		etc. (Specifi	)					City or Tou	vn, State)			il Route Numbe	эr,
Hosp	hin 24 ho the Fune npleted fi	Medical	(Check 2 only one) 3	☐ Certifying	xaminer:	On the basis of	examinatio	n and/or invest	tigation, in death occ	n my opinio urred at the	n, death occur time, date an	rred at t	the time, date a	and place, e cause(s	and due	e to the ca anner as s	ause(s) and man tated.	iner sta
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:05 PM Dwight Richardson March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) unk 1 🕅 M 2 🗆 F Months Days Hours Min May 21, Year 961 Director 48 220-80-2001 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 2304 Belair Road USA unk 12. Was Decedent Ever in U.Sunk | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No within 72 hours after 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates black 3 Divorced Completed and 2 should be filed within 72 hour. Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical. unk16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 E. University Parkway Baltimore, MD Union Memorial Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o permit. Page 1 Department of Important: If ii any injury or or 1 Burial 2 Cremation 3 Removal from State 4 Donation 3 M Other (Specify) Danie Thateand Adda to his ill Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition resulting in death) year Medical **Examiner** ectic Circhosis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Yes 2 No 9 Unknown 9 Unknown To the Hospital or Attending Proyecum.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed the standard of the Funeral director, page 2 should be defined in by the funeral director, page 2 should be defined to the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗌 No Yes 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No 욘 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 22, 2010 who completed cause of death (Item 23a) (Type, Print) Memoria

Registrar DHMH 17 Rev 7/2009

State

21215-0036

Maryland

Baltimore.

Box 68760

P.O.

Records,

**Division of Vital** 

32. Registrar's Signature

Polloc

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 105 MAUWARD ummero Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Northwest Hospital Randallstown Baltimore Co Birthplace (State or Foreign Country) . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours 10/28/1944 1 🛣 M 2 🗆 F Director 65 Maryland 212-44-5247 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3132 Belmont Ave. 21216 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married ð Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade Security Race Track other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಡಿ Charles L. Summerville Maelo Stanlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daona Barnes(Niece) 602 Winans way, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Joseph Cremetory of Other place H And Crematory 1 Burial 2 Excremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 04/01/10 Baltimore, MD 21. Sign story of Funeral Service License Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or neart failure. List only one cause on each line. Imprediate Cause (Final Onset and Death -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause Disease or if that initiated events resulting in death) Last and Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Vear 9 Unknown <u>О</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this o 4 Nursing Home 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State 24 hours Medical 😾 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number

34

DHMH 17 Rev 7/2009

State Registrar apre and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's S

2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 725 & 27 per MD 8901 3/31/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CNOWDEN Day Year **Physician** Month OOPM Harch 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown NorthWEST HOSPITAL Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
BAI'to, Md 6. Sex Funeral 214-54-5958 1 ☐ M 2 🗗 F Months Days Hours Director Dec. 1, 1957 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Modical Examble to retified a once. 1 Yes 2 □ No Director MD BALTIMOYE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5304 21207 Norwood U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ If Yes, Give 1 □Yes 2 No Specify: Specify: BIACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HouseWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARION YATES CARRIE YATES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISRAEL CASON - HUSBAND 5304 Norwood Ave. BALTIMORE Md 21207

Date | 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEM PARK 3-25-10 RANDALLSTOWN, Md 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
PARKET F. H.

3512 Frederick AVE. BA Ho.

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 3512 Frederick AVE. BAJto. Md. 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HyperKalemia /Medical Due la as a consequence of): Examiner End Stage RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a sunsequence of): attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed certificate has b rector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 210 1 □Yes 2 400 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death

To the Funeral Director; /
completely filled in by the f 2 Accident Catild not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and nanner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier
Abdallah Rafrouni, 29c. License number 29d. Date signed (Month, Day, Year) D65843 March 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randalls town, HD 21133 Abdallah Kafrouni, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Darko Registrar

DHMH 17 Rev 1/2001

Pattert Knawn as Hattle Smith

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			For State Registrar	State of M	aryland / Dep Ce	artment of		i Mental H	ygiene Reg. No.	010 098	87
	Physicia	n/	1. Decedent's Name (First, Middle, La	ast)				2. Date of D		3. Time of De	
	Medic	al	Hattie 4a. Facility Name (if not institution, giv		ene		Smith	March	27	2010 11.50	A <sub>M</sub>
	Examin	er	Smai Hospita	1 of Ba	I Am ore	Ball If Under 1 Year	or Location of De	le_		y of Death  9. Birthplace (State or Fo	roian
П	Director		216 <b>-</b> 40-2302	1 □ M 2 <b>X</b> □ F	83 Yrs.	Months Days				Country) NC	neign
	land show dat	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City L	
	e Mary r 28a-i notifie	Jirec	MD NA  10e. Street and Number		Balti				·	1 🖔 Yes 2	□ No
	with th	Funeral Director	3600 Durley La	ne		10f. Zip Code	21207		-	What Country?	
	death items		11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	Hispanic Origin?	(Specify Yes or No		ce - American Indian,	
-0036	ours after itural", or	eted by	1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🛣 No	Specify:		Specify	ck, White, etc. : Black	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fire I and Mental Hygiene. Important: I fire I are I is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 9th grade		(Give	dent's Usual Occu kind of work done O NOT use retired Nurse	during most of w	rorking	Melcor Home	Business Industry Ce Nursing	
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Man	2 shouli h and h 7 is ma trauma		19a. Informant's Name/Relationship (			ng Address (Street					
	of Health of Health fitem 27 rother tra		Shirley Brown- 20a. Method of Disposition	-Daughter	20b. Place of Dispo	Durle	<u>-</u>	Date	<del>'</del>	- City or Town, State	
	Page ment o tant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Garrison	natory or other pla n Fores		4/5/10	1	s Mills, Mo	ł
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fulleral Service Licer	19/1.	Ŋ	Name and Address	H West	a. Balt	imore.	Md 21215	
		-	23 Part 1. Enter the disease, or con shock, or heart failure. List only	applications that caused	the death. Do not ente					Approximate	
~ P	hysician/		Immediate Cause (Final disease or condition	a huser	cannelo	Pesol	satoru	Garline	0	Interval Betwee Onset and Deat	
'	Medical Examiner		resulting in death)	Due do (or as a	consequence of):	APD	7	•		1260 05 3	بالمماد
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x 687	tending r use a	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal death 3 🗆	] Ectopic pregnan	су		- 1	ate of delivery	
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<u> </u>	rnysi rthis c	일	1 Yes 2 No 27. Manner of Death	Hospital:  1 Inpatie  28a. Date of injur	ent 2 ER/Outpatier y 28b. Time of	ot 3 DOA Oth	4 L Nursing	Home 5 Resi			
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Division of Vital Records,	within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	al Certificate:	3 Suicide 6 Could not I determined		ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location ( City or To		er or Rural Route Number,	
	24 hou	Medical	Uneck 2 Medical Exam	vsician: To the best of rainer: On the basis of ex	amination and/or invest	idation, in my opini	on, death occurre	d at the time date.	and place, and du	e to the cause(s) and manner	stated
	within To the comple	_	29b. Signature and title of certifier	se Practioner: To the h	nest of my knowlinging	29c. Licens	e number	siace, and due to the	29d. Date signe	d (Month, Day, Year)	_
			- June 11/16	olgu MI	)	KE:	> 000	)	March	27,2010	)_
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, P	rint) Oli Mal a	1 Baltis	10RE 241	Ol W. Bels	redere Ave	
4	Stat Registra	-	31. Date filed (Month, Day, Year) MAR 31 2	32. gistra	s Signature	ares			Baltomore	d (Month, Day, Year) 27, 2010 COKRE AVE 2, MO 2121	5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year March 30, Shields 6:15 Tris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7802 Bagley Avenue Baltimore Parkville 8. Date of Birth (Month, Day, Yea 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 M 2 XX Months Hours 218-28-2665 78 Director March Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland fifth and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 United States Funeral 7802 Bagley Avenue . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Kathleen R. Mooney 17. Father's Name (First, Middle, Last) Francis H. McCully if. Page 1 and 2 shou...
if of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorald Sheilds, Sr. - Spouse 7802 Bagley Avenue, Parkville, Maryland 21234 permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other th 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) April 5,2010 Parkville, Maryland . Signature of Funeral Service Licenser <sup>22. Name and Address of Facility</sup>
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkviile, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death by the 9 Unknown detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen sure 24b. Were autopsy findings available prior to completion of cause of 24a, Was an nas autopsy performed? Yes 2 X No certificate 1 Yes 2 No Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/30/2010 D37133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denna L. Drw MD 76 00 051en Drug

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31. Date filed (Month, Day, Year) State

32. Distrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09889 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ VEOLA Year 2010 SHEETS 1:20 P M MARCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 238-30-7150 1 □ M 2🛣 F 98 Months (Month, Day, Year) 1912 Director Jan, North Carolina Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d, Inside City Limits ems 23a or 28a-f sh r must be notified a Pylesville Harford County Maryland 1 Yes 2 W No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21132 1887 Eden Mill Road United States ural", or items ! 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed 3 ♥ Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home N/A Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sumame)
Minnie Alice Darnell James Franklin Sheets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Anna Sadler (Daughter) 1887 Eden Mill Road, Pylesville, Maryland 21132 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Laurel Springs, N.C. 3/31/2010 4 ☐ Donation 5 ☐ Other (Specify) Peak Creek Church Cem . Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - BelAi er Maryland 21050 Forest Hill Newport Drive, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physiciali disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, page 1 ☐ Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 🗌 Yes Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only lane) Contifying Nurse Fractioner: T. the best of my knowledge, Seeth occurred at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number Daw 032291 26, 2010

State

Registrar

barke

DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014

32. Regis rar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 31 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09890 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Susan Anne Spangenberg 2010 12:12 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 54 Yrs. Director 218-70-7075 Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 224 Timber Trail Unit D S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress and Mental Hygie is marked other Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Alfred F. Navarria Marion C. Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Timber Trail Unit D. Bel Air, Maryland 21014 Mrs. Marion Navarria (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
Evans\_Funeral Chapel 1 

Burial 2 

Cremation 3 

Removal from State March 29, 4 Donation 5 Other (Specify) Forest Hill, Maryland 2010 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services — E 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ obolle disease or condition 5 years Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ronchi Examine Due to (or as a consequence of): that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Month Day Year ed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate ! 2 No 1 Tyes nin 24 hours after death.

the Funeral Director: After this certific peleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Yes 2 □ No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined Medical 29a. Certifier 1 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number m 065411 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havre de Grace, beorg Ave. State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Year 2D1 100P Streckfus Mildred Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death G) Day ISNY <u>Baltimore-Washington Med</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 □**X**E Months Days Hours Country)
Maryland Director 212-03-1767 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2054 Kurtz Avenue 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 🖫 Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Pay Roll Officer Army Corp of Engineers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ  $\underline{ ext{Timothv}}$ <u>Kenne v</u> Mildred <u>Dovle</u> permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Streckfus (Son) 2054 Kurtz Avenue Pasadena. Marvland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 03/27/2010 Baltimore, Maryland 21. Signature of Fureral Service Licensee 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each lin shock, or heart failure. List only one cause Immediate Cause (Final Row Onset and Death Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68769 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Day Year g Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 sl perform After this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ ↑ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours area. To the Funeral Direc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Scartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only on 29b. Signatur d title of certifier 29d. Date signed (Month, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Date filed (Month, Day, Year)
MAR 3 1 2010 Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 28, 2010 **Physician** WANDA RUTH SCHWABLINE 6:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y August 3, 5. Social Security Number 7. Age (In yrs. last birthday) <sup>Year)</sup> 1926 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 👿 F West Virginia 235-38-4057 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified in Maryland Anne Arundel Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 214 Camrose Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Box Company 12 Office Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LaFayette Snyder Mamie Johnston ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burchard L. Schwabline (Husband) 214 Camrose Avenue, Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4/1/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INFARCT MYOCARDIAL /Medical Due to (or as a consequence of): CORONARY Examiner ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMONAR FIBROSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed GASTRIC LILCER 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' 1∐ Yes 2 **N**0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ZER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) harmander, M.D. 3-30-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24. BALTIMORE, MD 21225 K.S. DHARMASENA, M.D. 3721 POTFE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 31 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Month 10:52 AM in Porch 2010 12 /Medical aro or Location of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town. 4c. County of Death Examiner Secours Hospi Timore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Davs Hours Min. 218-28-7789 74 07/20/1935 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examples in ust be routified at Director 1 Tyres 2 □ No <u>Balti</u>more MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1026 Bennett Place 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 2 3X Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Homemaker N/A Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Smith traumatic ဂ Lola V. Ayers of Health and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 Bennett Place, Baltimore, MD 21223 Vernon White(Son) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 04/02/10 Baltimore, MD Garrison Forest 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Joseph H. Brown Jr. Funeral Home macolo Jeane 2140 N. Fulton Ave., Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter the driving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tra Due to (or as a consequence of) attending physician for use as the hurial Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 2 No 1 ☐ Yes 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy \_performed1 certificate 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: \$\overline{x}\$

Baltimore, Maryland 21215-0036

State Registrar

one)

30. Name

29b. Signature and title of certified

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2010

10-02315	
Melissa Wahnbaek	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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r m	0	1	U	0	7	0	7	i.

		I- For State Registrar Certificate o	f Death	Re	g. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Deatl Month		3. Time of Death
edical Exami	ner	MELISSA INGRID WAHNBAECK		March 22,	2010	1315 hrs
		4a. Facility Name (if not institution, give street and number) 5011 Anthony Avenue	4b. City, Town, or Location of Death Baltimore	1 	4c. County of De	eatn
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir	, –	h(MM/DD/YYYY) 9. Fo	reign
Director	Į	302-74-0582 1 M 2 X F 45 Yr		Feb 21	, 1965	Country) Ohio
<u> </u>	- 1	Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Loca	tion			10d. Inside City Limits
,						1 Yes 2 No
Maryland 28a-f show any <u>d at once.</u>	용	MD Baltimore  10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	
he Ma or 28	Director	5011 Anthony Avenue	21206-5127		U.S.A.	
with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? ( S	pecify Yes or No-	14. Race - Ar	nerican Indian, Black,
21215-0036 Mehal Hygiene. marked other than "natural", or items 23a or 28a-f she revent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If 1 Yes 2 XXNo	Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, et	С.
s after ral",	b	3 Widowed 4 XXivorced If Yes, Give Year 1 or Dates:	Yes 2XX No specify:			White
hour:	te d		nt's Usual Occupation (Give kind of nost of working life. DO NOT use ref		16b. Kind of Busine	ess/Industry
36 hin 72 e. than	Completed		-employed		Hat Mal	ker
21215-0036 valid be filed within 7 Mental Hygiene. marked other than it event, the Medica	5	17. Father's Name (First, Middle, Last)		e (First, Middle, N	1	
215 be file ntal H rked	-	Gerhard H. Wahnbaeck	Gerlind	de Burda	ck	
21 hould nd Me is ma	2		ng Address (Street and Number or			
MD and 2 should alth and 37 is m 27 is mumatic			7 Twin Hill Lane	Laurel	, Maryland	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene. Fant: If liem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 XX remation 3 Removal from State crematory or o	ther place)			
Baltimore, MD oemit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other fraumat		4   Donation 5   Other Specify.				, Maryland
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee 22. M00770	Name and Address of Facility Onaldson Funeral 13 talbott Avenue	Home, P	.A.	nd 20707
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter				Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Carbon Monoxide Toxicity				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	٦	Sequentially list conditions, if any, leading to immediate  b				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
ed nsit	Exa	events resulting in death) Last  Due to (or as a consequence of):				
760, cate be executed physician and the burial - transit	/Medical	UNPENDED AMENDED				
ficate be g physics the buri	₩e	IF FEMALE: 23b. Was decedent pregnant in the 2 2sc. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregn	ancy.	23d. Date of deli Month	ivery Day Year
Sox 687 leath certifing e attending for use as t	/sician/	past 12 months?  4 Pregnant at time of death 5	etal death 3Ectopic pregn other (Specify)	iai ioy	Morra	Day
<b>₩</b> % Æ 8 I	Phys	1 Yes 2 No 9 V Unknown 9 Unknown				
etach	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			e to the cause of death?  Probably 4 Unknown
S, P, quires then signe and be d				24a. Was a		e autopsy findings available
cords, law require has been si	ple			autop	sy prior	to completion of cause of
tal Rec ian: The l certificate l	Completed			1 ✓ Yes		
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n of V ding Phys After thi funeral di	. To	27 Manner of Death 28a Date of Injury 28b Time of			now injury occurred	outer. Occite
on on carry ath.	tion	1 Natural 5 Pending FOUND: FOUND: FOUND: 1300 hrs	1 Yes 2 ✔ No	Inhaled fum	es from lit char	coal grill
Division tal or Attendi safter death. al Director: /	fica	2 Accident Investigation Mar 22, 2010 1300 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.			r Rural Route Number, City
Division of Vital Hospital or Attending Physician: 94 hours after death. 75 femeral Director: After this certifiely filled in by the funeral director.	Certification:	4 Homicide determined (Specify) Single Family Home		or Town, S 5011 Anthony	Avenue, Baltimor	re, MD
To the Hospital within 24 hours To the Funeral completely filled	edical (	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investig				
7 × 5	Me	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, Day, Year)
		Course Hallan	O.C.M.E.		March 23, 20	10
MV		30. Name and address of person who completed cause of death (Item 23a)				
9		Carol Allan, MD Assistant Medical Examiner 111 Penn  31. Date filed (Month, Day, Year) 32 Pegistrar's Signature	Street, Baltimore, MD 2120	דט		
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30. Name and address

31. Date filed (Month, Day, Year)

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RD. RANDAULETOWN

person who completed cause of death (Item 23a) (Type, Print)

540

32. Registrar's Signature

10-02434 Debra Lee Whitley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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			1- For State Registrar			_		Certific	ate of	Deat	th				Reg. No	). D.	1 0	0 0 0 0 0	
Physician/ Medical Examiner			Decedent's Name (First, Middle,Last)											2. Date of Death Month Day March 27, 2010  3. Time of Death 0920 hrs					
7			Facility Name (if not institution, give street and number)     1959 Holborn Road							b. City, Dund		Location	of Death	4c. County of Death Baltimore County					
	Funeral Director		5. Social Security N		6. Sex	2[X]F		In yrs. last bir 4	thday) Yrs.	Month	er 1 Yea		er 24Hrs. Min.	8. Date of 3 – 1 –			Foreig	hplace (State or n untrGermany	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of 10a. State MD 10e. Street and Nu 6944 Br	10b. County Balti mber	.mor					10f. Zip Code 21222						Citizen of What Coun		10d. Inside City Limits 1 Yes 2 No	
		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced If Yes, Give Year  15. Decedent's Education (Specify only highest grade completed)					No leted) 16a.	If Ye	As Decedent of Hispanic Origin? (Specify Yes or No- /es, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 X No specify: Spe						14. Race White Specify:	4. Race - American Indian, Black, White, etc. Specify: White		
		To Be Completed	Elementary/Secondary (0-12)  12  College (1-4 or 5+)  Computer Technician  Computers  17. Father's Name (First, Middle, Last)								s								
			Harold S. Whitney Verna Snyder									n State	Zin Codo)						
			Wanda Core - Sister 2502 Alexander Ave, Edge								lgen	mere, MD 21222							
			20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  BayView Crematory 3-30-10  Balti									ltim	ore	, MD					
		Ç.,	21. Signature of Furneral Service Ucensee  22. Name and Address of Facility Bradley-Ashton Funeral Household Willow Spring Road, 21222																
	Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Bronchopneumonia  Between Onset an Death												Approximate Interval Between Onset and Death				
		_	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.																
	d sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence												_		7		
	Box 68760, he death certificate be executed the attending physician and ned for use as the burial - transit	edical E	d. □XUNPENDED □ AMENDED 23a,27,perm,E g903 5/6/10 TT																
		Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy								3		pregnar	ncy	23	Bd. Date of Month		ay Year	
	ires that the signed by the detached	ã	1 Yes 2 V No 3 Probably 4 Unknown																
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	Division of Vital Records, P.O. Box within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atternoon period of the funeral director, page 2 should be detached for upon period.	ation: To									y at Work?								
		Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		dical	one) 2 🗸	Medical Exa	miner:0		of examin	nowledge, dea ation and/or in		on, in my	opinion	, death occ							
		Me	29b. Signature and title of certifier  Augustus  Augustu							29c, License number O.C.M.E.					29d. Date signed (Month, Day, Year) March 28, 2010				
			30. Name and addre Margarita Ke			npleted caus		,	111 Pe	nn Str	eet, Ba	altimore,	, MD 2	1201	•				
	St Regis	ate rar	31. Date filed (Mont		2010	32 Re	egistrar's S		pare										
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 26, Day 2010 **Physician** 2:45 a M Wilson Walter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Woodridge Manor Care Woodlawn Hours Min. July 20, 9. Birthplace (State or Foreign S. Country) 7. Age (In yrs. last birthday, **Funeral** Months Days Year 914 1 🙀 M 2 🗆 F 248-26-3895 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hurry or other traumatic event, the Madden Exact it are must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1▼ Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21223 2133 Penrose Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ∐Yes 2 🕱 No Specify <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Saw Operator 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson Gamble Abraham ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Ramsome (Niece) 155 Palormo Ave. Baltimore, Maryland 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Loudon Park Cemetery 4/1/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. \_\_\_\_me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYPERTENSIVE **Physician** CARDIOVASCULAR DISEAS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I ☐Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ WAZL CELLULITIS 2 No 3 Probably 4 Unknown 1 Yes page 2 should Be Completed CEREBRO-VASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral TECETITY Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5059 -2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING DRIVE 60 STONEY BALTIMORE 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar Denna

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			1. Decedent's Name (First, Middle, Last)	Wisni	ewski	2. Date of Deat	h	3. Time of Death 2:35 A M
**			4a. Facility Name (If not institution, give street and number)				4c. County of Death	
and the	/.		119 Elm Avenue		Glen Burnio	е	Anne Arund	e1
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year   If Under		9. Birthpl	ace (State or Foreign
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	arylar show	-	10a. State 10b. County	IOc. City, Town or Lo	cation		110	
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ary	shou and N s ma		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Numb			
Σ	and 2 saith 27 i		Thomas C. Wisniewski (Son)	1125	Waldorfs Cou	rt Decatur GA	A 30033	
ore	of He		20a. Method of Disposition	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date	20c. Location - City or Tox	wn, State
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ш	ಜರಕ ಕರ		John K bllen		3204 Mountain	Road Pasader	na, Maryland	21122
			23a. Part : Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ent	er the mode of dying, such as	s cardiac or respiratory arre	est,	Approximate Interval Between
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			resulting in death)  Du to (or as a continuous)	consequence of):	0			
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P.O. Be	0 0 0	hysiciai	in the past 12 months?					•
Š,	ss tha gned se del		Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part	1. 23e. Did tob	pacco use contribute to the	e cause of death?
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ecc	law r as be 2 sh	ble	Dysphagia				24b. Were autop	osy findings available
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<u>&gt;</u>	hysic his of		Hospital	2 ER/Outpatier	t 3 ☐ DOA Other: 4 ☐ N	ursing Home 5 Reside	nce 6 ☐ Other (Specify	')
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Sio	tendi eath. or: A	cati	2 Accident investigation			]No		
Division of	or At ifter d Sirect in by	Ħ	determined   286. Place of injury	- At home, farm, stre (Specify)	eet, factory, office	28f. Location (St. City or Town	reet and Number or Rural , State)	Route Number,
	pital ours a eral [ filled		20g Cartifier Decertifying Physicians To the heat of	my knowlodgo dost	a continued at the time and the			
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	ompl.	Me			29c. License number	25	9d. Date signed (Month, L	Day, Year)
	- >-0				D0066	019	Marcilas	9 2010
,			30. Name and address of person who completed cause of dea	th (Item 23a) (Type	Print)	2.22 202	Mary NI	1 2010
			4710 Penningto	m Ac	- Ran	the Car	51336	
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	The Control Part												
			4a. Facility Name (if not institution, give s	treet and number)			4b. City, Tow	_	_	Mina	4c. 0	County of Dea	th
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			Usual Residence of Decedent					,-		May 27,	"1927	Mar	yland
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yland 2	d be filed w Mental Hygi arked other atic event, t	Be	17. Father's Name (First, Middle, Last)		<b> </b>		CTEIK	I .		` '	Maiden Su	ırname)	
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Baltimore,	t. Page 1 a tment of H tant; If ite ijury or ott		1 <b>X</b> Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemete	ery, crem even 1	tem. Parl	: (	04-02-	2010	Glen B	urnie, M	aryland
Bal	permit Depar Impor any ir		21. Signature of Funeral Service License	Hour	ach								ome P.A.
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), Box 68760	he death certificate y the attending phi iched for use as th	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	Sc. If yes, outcome of p 1  Live Birth 2 4  Pregnant at tin	☐ Fetal deat						23		
3, P.O	es that tesigned besta	þ	Part II. Other significant conditions con	tributing to death but r	not resulting	in the un	derlying cause	given in Part	t I.				
ecords	ne law requir e has been a age 2 should	ompletec	,							24a. Was auto	an osy ormed?	24b. Were aut prior to death?	opsy findings available completion of cause of
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	o vitt		29b. Signature and title of confiler	2 m 0				nse number	07/6	١.		signed (Month	
			30. Name and address of person who cor	npleted cause of death	(Item 23a) (	(Type, Pri	nt)		/ ( /			u, ∽ o,	2010 na 21061
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARCH :10P 26 SAMUEL YOUNG ADEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday)
52 yrs. Birthplace (State or Foreign Country)
 MD 5, Social Security Number 216-78-2345 If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Ye Months Days Hours Min Director MD 195 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director or 28a-f Fredrick MD Monrovia 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a ( Funeral 4716 Lynn Burke Road 21770 USA items ; 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No or, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural", 3 Divorced 4 Divorced Specify: the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Paving Company 11 Laborer Paving Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert L. Young Nina Gottman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1632 Locust, Quincy, IL,62301 Nina Young ( Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Dother (Specify) Graceland Cem. 3/30/10 Quinci, IL 21. Signature of Europal Servicensee 22. Name and Address of Facility 1435 State Street Cookson F.H. Ouincy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pitysician heroscler disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the i 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed Yes 2 After this certificate I 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural iniury 5 Pending Investigation
6 Could not be 1 Yes 2 No s after death Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29c. License number

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#8perFH, 3/24/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <sup>Day</sup> 2010 Janice K. Atwell 3:30 A<sup>M</sup> Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birun Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗗 F Days Months Hours Min. 58 **Director** 216-62-1380 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20853 4409 Holly Ridge Road United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify:White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Albert Kassakatis Sr. Ida Mae Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Ward / Spouse 4409 Holly Ridge Road, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important; If it
any injury or o ☐ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 3/16/2010 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, de heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Examiner Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ been signature should ! Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed? certificate 2 No Yes 2 No 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) Other: မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Casey House After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined ما24 hou، ح **the Funeral Dire** ما filled in Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune
completed f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) 3/12/2010 D60634

State Registrar 31. Date filed (Month, Day, Year)

Washington, D.C. 20017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu C. Joseph 1160 Varnum St. #021

			1 - For State Registrar	State of M	arylan				ealth a			gien		0	09902
П	Dhysia	ion	Decedent's Name (First, Middle, L.	ast)	Λ						2. Date of De	ath Da	ıv Y	/ear	3. Time of Death
	Physic: /Medi		Helen O A	rmstead	1.					1	March	14		010	1812 <sup>M</sup>
	Exami		4a. Facility Name (If not institution, g	ve street and number)	)		4b. City	, Town, or	Location of	of Death		40	. County of	Death	
			Holy Cross Hosp						Spr				Mont		
	Funeral			Sex 7. Ag 1 ☐ M 2 ☒ F		last birthday) Yrs.	Months Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year			lace (State or Foreign try)
	Director		370-12-6320 Usual Residence of Decedent		90						Feb. 16	19:	20 N	1ich	igan
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				-			1	0d. Inside City Limits
	Man,	ţō	MD Montgo	nery	Ge	rmanto	wn								1x Yes 2 No
	r 28e	Director	10e. Street and Number				10f. Zij	p Code				10g. C	itizen of Wh	at Coun	itry?
	h wit	ie D	20323 Cedarhur	st Way				20876	·				US		
	72 hours after death with the Maryland Instural', or Iteme 23a or 28e-f ehow digal Exer's or must be inclined at	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	.S. 13.	Was Dece	dent of H	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race -		
9	or Ite	正	1 Never Married 2 Married	1 ☐ Yes 2 ☒			1 ☐ Yes			i, Fuelto	nicari, etc.)			White,	
8	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:									Specify:	Blac	:k
<u>7</u>	be filed within 72 hours ital Hygiene. Id other than "natural", event, Ite Medical Exe	Completed	15. Decedent's (Specify only highest g			16a. Dece (Give	dent's Usu kind of wo	al Occupa	ation <i>luring</i> mos )	t of worki	ng	16b. F	Kind of Busi	ness/Inc	dustry
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7	at Hygie other		17. Father's Name (First, Middle, Las	4		Progr	am A	nalys		ar's Name	(First, Middle				ernment
ano		Be C		•									i Sumame)		
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Maryland 21215-0036	id 2 sho lth and 27 is ma treuma		Jacqueline Star			1	•		rst V						
ē,	s 1 and 2 should if Health and Mer Item 27 is marke other treumatic		20a. Method of Disposition	L / NIECE	20b. P	Place of Dispo	sition (Na.	me of		- 18	German		ocation - C		0876 wn, State
5	ages ant of it: If I		1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec			emetery, crei	-		1	2/0	0./10	_			-
Baltimore,	permit. Pages of Department of Himportent: If Ite any injury or ot 20.52.		21. Signature of Funeral Service Lic		FOI	t Line	OLD 2. Name a	orema	atory	3/2	2/10 1 Blade	Bre	ntwoo	d, M	
Ba	Depa Impo any i		West Miles	res							i Blade 1 Home	ensp			20722 rood, MD
	Physician /Medical Examiner	iner	23a. Part. Enter the disease, or co shock, or heart fail/free List only insease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Athero: Due to (or as	scler	tic Co uence of):									Approximate Interval Between Onset and Death
68/60,	death certificate be executed e attending physician and id for use as the burial-transit	ledicai Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):									
		Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3	Ectopic p Other (s <sub>f</sub>						23d. Date Month		ny Day Year
S, D	requires that the een signed by th nould be detache	by P	Part II. Dther significant conditions	contributing to death b	out not resi	ulting in the u	nderlying o	cause give	n in Part I.		23e. Did t	obacco	use contrib	ute to th	e cause of death?
ğ	w require been sig should b		<u>Diabetes Mellit</u>	is A	Advan	ced De	ment:	ia			1 🗆 '	Yes 2	□No 3	☐ Proba	abiy 4 🛣 Unknown
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<b> </b>	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				0#	. 5		Check onl				
o		유	1x Yes 2 No 27. Manner of Death	1 ☐ Inpatie		ER/Outpatien 28b. Time of		-	4 140		ne 5 Resi				′)
ב	ding Ph h. After th funeral	tion	1 ☑ Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м 1	28c. Injury Work	ai ?? /es 2 ☐ I		zod. Describe	now inju	iry occurred		
=	or Atten ifter deat Director: in by the	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	00 - 01					63 2 0	-	28f. Location (a City or Tou			or Rurai	Route Number,
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	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29	c. License	number			29d. Da	ite signed (	Month, L	Day, Year)
	, and		7. annow					D006.	5301			Mar	ch 15	. 20	10
2	5		30. Name an address of person who	completed cause of c	leath (Item	23a) (Type,	Print)						J.1. 1.J	, 20	
			Farzana Ajmal,	MD 13917	Coach	man Ci	Lrc1e	Ge	rmant	own.	MD. 2	2087	4		
	Sta Registr		31. Date filed (Month, Day, Year) <b>MAR 1</b> 8 2010	Server 32. Registr	ars Signa	and I	,								

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

3altimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed Director: hin 24 hours af the Funeral D mpletely filled in within 2.

Medical 29b. Signature and title of certifier ansima, MD

29a. Certifier

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

51705

29d. Date signed (Month, Day, Year)

Westminster, MD 21157.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANGURIYA 349 Malwim

31. Date filed (Month, Day, Year) MAR 1 6 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Brown 08 1225 Lean EIVIS 03 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY Cross Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 ☐ F 31 979Jamaica 219-25-0819 Yrs 02 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Engineer could be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 ☐ No **Funeral Director** MD Beltsville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20705 Jamaica 3504 Dunnington Rd 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: 1 ∐Yes 2 TNo ρ Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Field Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Neil ည Elgin Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dunnington Road, Beltsville, MD 20705

(Name of Date 20c. Location - City or Town, State 3504 <u>Leba Brown</u>, Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 03/19/2010 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Care (Final disease or condition resulting in death) **Physician** Duodenal Cancer /Medical Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Respitory Failure and burial-trar Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Hospital or Attending Physician: The law requires ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA dire Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation in 24 hours after death.

he Funeral Director: Aft
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 03-08-2010 D66162

State Registrar Edith N. Aniedobe 1500 Forest Glen Rd. Silver Spring, MD 20910

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			State of Maryland / Department of Certificate of State			2010	09905
			1. Decedent's Name (First, Middle, Last)	Di Dealli	2. Date of De	Reg. No.	3. Time of Death
	Physicia		Peter Balodimos		Month March	Day Year 14, 2010	2:23P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Tow	n, or Location of De	ath	4c. County of De	ath
d'			Atlantic General Hospital Berl		rs. 8. Date of Bir	Worcest	
	Funeral Director			ays Hours Mi		ay, Year) 7.1932 Wa	irthplace (State or Foreign Country) ash., DC
	р		Usual Residence of Decedent				10d. Inside City Limits
	arylan show	ř	10a. State 10b. County 10c. City, Town or Location				1 □Yes 2√□No
	he Mi	ecto	Maryland         Worcester         Ocean         City           10e. Street and Number         10f. Zip Co.	de		10g. Citizen of What (	
	with t	٥	13317 Atlantic Boulevard 2184			United Sta	ites
	ms 2%	nera	13317 11616116116 - 1 - 1 - 1 - 1 - 1 - 1 - 1	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No		merican Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination into notified at once.	by Funeral Director	1 □ Never Married 2 ▼ Married  1 □ Yes 2 □ No 1949 − If Yes, Give Year or Dates: 1952		,	Specify: V	
113-003	in 72 hor n "natur Nedical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	one during most of v	working	16b. Kind of Busines	
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aud	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)	I	Name (First, Middle .ke D. Bal	, Maiden Surname)	
<u>X</u>	ould to Men	٩	William Balodimos  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Si				a. Zip Code)
Mar	d 2 sh th and 7 is n traun		Barbara Ann Balodimos Spouse 13317 Atlan			ean City, N	
e,	t Heal f Heal item 2 other		20a. Method of Disposition  20b. Place of Disposition (Name of ceretery, crematory or other)		r 19,	20c. Location - City	or Town, State
e E	Pages nent o int: If i		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Ceme			Brentwood,	Maryland
Бант	permit. Departn Importa any inju					neral Home Gaithersbur	g, MD. 20877
			23a. Part 1. Enter the disease, or complication: het caused the death. Do not enter the mode o shock, or heart failure. List only one caus an each line.				Approximate Interval Between
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
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J.	the by th	hysi	9 Unknown		1		to the second of death 2
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Ö	s beer shou	Completed			24a. Wa	s an 24b. Were	autopsy findings available to completion of cause of
He He	The law ate has bage 2 s	I Wo			per 1 □ Yes	formed? deat	h? Yes 2 □ No
Vital		Be C	25. Was case referred to medical examiner?		Death (Check only	one)	
<u>&gt;</u>	Physic this coral dire		1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA			sidence 6 Other (	Specify)
Ü.	ding F h. After funera	ion:	Makurai S Periding	. Injury at Work? 1 □ Yes 2 □ No	20d. Describe	e now injury occurred	
Division of	ten leat tor: the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice	28f. Location City or T	(Street and Number o	r Rural Route Number,
Ω	To the Hospital or At within 24 hours after of To the Funeral Direct		29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in	the time, date and p	place, and due to the occurred at the time	ne cause(s) and manne e, date and place, and	er as stated. due to the cause(s)
	the H hin 24 the F mplete	Medical	and manner stated.			20d Data signed //	footh Day Voorl
		/	Solver and the original of the solver of the	46257		3.15	-2010
	3+1	(	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  COLOR CASTON EDA WID 10324 020 0Ce  31. Date filed (Month, Day, Year)  22. Registrar's Signature	MCETT	BCVD (	wend,	WD 21811
		ate	31. Date filed (Month, Day, Year)  2010  22. Registrar's Signature	, , , ,		ť	/
	Regist	rar	The court of the same of the same				

Pate Balodimos DoB 2/17/1932 DOD 3/14/2010 TOD 1423

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 March 21:16 PM William J. Barry, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Union Hospital of Cecil County Elkton 9. Birthplace (State or Foreign CountBrooklyn New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec. 8,1 7. Age (In yrs. last birthday, **Funeral** Days Hours 1**XX**M 2 □ F Dec. 1928 Director 076-22-4009 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director XXYes 2 No Maryland Cecil North East 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a Funeral 520 South Main Street, Apartment 203 21901 United States items ; 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2XXNo Specify White Specify: 3 🛱 Widowed 4 □ Divorced "natural", Completed Year or Dates. US Navy permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E any injury or other traumatic event, the Medical E. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0~12) College (1-4 or 5+) Security Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ William J. Barry, Sr. Eleanor Doran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven C. Barry / Son 212 Sycamore Road, Elkton, Maryland Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate 17. 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 2010 Newark, Delaware 21. Sign ture of heral Service 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or co implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List onl one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available י Hospital or Attending Physician: The law ו 24 hours after death. י Funeral Director; After this המדולוה מל החיי prior to completion of cause of death? performe within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

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30. Name and address of persor

arise of death (Item 23)

			For State Registrar	te of Maryland		irtment of Hea tificate of Dea			7.0	0	09907
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Dea	Dav	Year	3. Time of Death			
	Medic Examin	al	THEO BLANG  4a. Facility Name (if not institution, give street and		BUFO	4b. City, Town, or Loca	ation of Death	March		2010	10;15A M
	LAGITAT		DOCTORS HOSPITAL	,		LANHAM					GEORGE'S
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 5	7. Age (In yrs. last b	oirthday) Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day,		9. Birthp Coun WASH	place (State or Foreign try) LINGTON . DC
	and show lat	ē	Usual Residence of Decedent  10a. State 10b. County	10c. City, To ORAN	wn or Loc	ation					0d. Inside City Limits
	Maryk 28a-f notified	irect	VA ORANGE	ORAI	NGE	,					1X Yes 2 □ No
	with the s 23a or ust be r	<b>Funeral Director</b>	10e. Street and Number 16628 MONROVIA ROAD			10f. Zip Code 22960			10g. Citizen of W USA	hat Cour	itry?
036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. ed Forces? Yes 2 X No s, Give or Dates.	If	/as Decedent of Hispani Yes, specify Cuban, Me ☐ Yes 2  No Sp	exican, Puerto F	cify Yes or No- Rican, etc.)		, White,	
15-0	72 hou "natu ledical	Completed	15. Decedent's Education (Specify only highest grade compl	(eted)	(Give k	ent's Usual Occupation ind of work done during	most of workin	g	16b. Kind of Bus	siness Inc	dustry
21215-0036	within giene.		Elementary/Seconday (0-12) Colle 2	ge (1-4 or 5+) YRS		NOT use retired) N. MANAGER			GOVERN	IENT	
Maryland	be filed lental Hy rked oth	To Be	17. Father's Name (First, Middle, Last)  JAMES CALLAHAN			18.		(First, Middle, M	Maiden Surname) AN		
Mary	should n and M 7 is mai raumat		19a. Informant's Name/Relationship (Type, Print)			Address (Street and N			-		
e,	1 and 2 of Health item 2 other t		HENRY BUFORD/HUSBAND  20a. Method of Disposition	20b. Place	of Dispos	MONROVIA I		ANGE VI	20c. Location - 0		
Baltimore,	t. Page tment c tant: If ijury or		1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)			atory or other place) E CREMATOR	Y 3/16	/2010	RIVERDAI	E,MA	ARYLAND
E E	permi Depar Impor any ir		21. Signature of Funeral Service Licensee		- 1	Name and Address of I 474 LANDOV			KINS FUI ER,MARYI		
1	Physician/		23a. Part 1. Enter the direase, or complications shock, or heart failine. List only one cause Immediate Cause (Final disease or condition	that caused the death. Do on each line. Sep tic	- i	the mode of dying, suc	ch as cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Medical Examiner			e to (or al a consequenc	e off.		lcer				
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	e to (or as a consequenc	e of):	ubitus c	ł				
	cate be executed physician and the burial-transit	al Exa	that initiated events C	e to (or as a consequenc	e of):	103611 00	11.3.4			_	
700	cate be physic the bi	edical	d	Stroke							
BOX PR	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completed birector. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	s, outcome of pregnancy Live Birth 2  Fetal de Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
ds, r.o.	quires that t en signed by	by	Part II. Other significant conditions contributing	cre				23e. Did tol	-		e cause of death?
Vital Records,	: The law recate has be page 2 sho	Completed	severe protein	calorie	Mo	dustrition		24a. Was a autops perfori 1 \(\sum \text{Yes}\)	sy pr		osy findings available impletion of cause of
/Ita	rsician s certifi lirector	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 Dinpatient 2 ER/	Outpationt	1011	Death (Check		ence 6 🗆 Other	Δ	
TO U	nding Phy th. After this funeral o		27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation		. Time of injury	28c. Injury at work?  M 1 Yes	2		w injury occurred		
INISION	l or Atten after dea Director: I in by the	Certificate:	3 Suicide 6 Could not be	Place of Injury - At home, building, etc. (Specify)	farm, stree			8f. Location (St. City or Town	reet and Number , State)	or Rural	Route Number,
ם	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	29a. Certifier (Check 2 Medical Examiner: On the	e basis of examination and	d/or investig	gation, in my opinion, dea	ath occurred at t	he time, date an	d place, and due t	o the cau	ise(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier  Donel Glex		William St.	29c. License num	ber		9d. Date signed	Month, E	Day, Year)
1/2	- 10		30. Name and address of person who completed Daniel alexande	cause of death (Item 23a	(Type, Pr	int)		oc Bo			
	Stat Registra		31. Date filed (Month, Day, Year) MAR 1 8 2010 Sensor	32. Registrar's Signature	4	.003 11011	11000	,	1		
	riegistra		PINT I O ZUIU CERCHIL	The Harry	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Claud J. Bethea 6:46 P M March 6, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5999 Emerson Street Apt. Bladensburg Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | Dec . 19, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛣M 2 🗆 F North 242-32-5401 Director Dec. Carolina Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Bladensburg Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20710 United States 5999 Emerson Street Apt. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 24 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 College (1-4 or 5+) Elementary/Seconday (0-12) 12th Private Carpenter marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Troy Bethea Cora Mckeever and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 404 Quarry Place Cynthia Bethea / Daughter Capitol Heights, Md. Baltimore, item 20b. Place of Disposition (Name of 20a. Method of Disposition 20c, Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot March 23 cemetery, crematory or other place)
Arlington
National Cemetery 1 🖾 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Rd. NE Washington, DC 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOPULMONARY ARREST Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ATHEROSCLEROTIC HEART DISEASE Sequentially list conditions, any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam **HYPERTENSION** Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Records, s been significant Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed: page 2 certificate | 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Da MARCH 15, 2010 MD# 13140

CR 2

Registrar
DHMH 17 Rev 7/2009

VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registra 's Sign

PATRICIA ANN WRIGHT,

31. Date filed (Month, Day, Year)

MAR 1 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ZO TO 1205 march Gladys Irene CALANDRELLE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital <u>Hagerstown</u> Washington Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Date or building (Month, Day, 1) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Maryland Director 215-64-0081 68 942 March Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 516 Jefferson Street 21740 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 Homemaker Her own home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Milton Richard Moats Pearl Auralia Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Charles Calandrelle - Husband 516 Jefferson Street, Hagerstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. injury Cedar Lawn Mem. Park: 3/23/10 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home estal Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death HEPATOL Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician Physician/Medical as for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? certificate 2 No Yes 2 or Attending Physician: 25. Was case referred to predical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ER/Outpatient 3 DOA 11 Inpatient 2 this filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Tes 2 🗌 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State Registrar 31. Date filed (Month.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15, 2010 Frieda Frances Month Coulon March 6:15a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign <sup>Year)</sup> 1<u>917</u> 1 🗆 M 2 😿 F Months Days Hours 084-05-5583 93 Director Croatia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Mon tgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22413 20882 Sweetleaf Lane USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items : 11 Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify: White 3 Widowed 4 ☐ Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Buick Antoinette Mavrovich 19a. Informant's Name/Relationship*(Type, Print)* Denise Fitzgerald/Daughter 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22413 Sweetleaf Lane, Gaithers burg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 H Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery March 1 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, Williansn MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Osepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 09/89 the ending pr. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) atter for u Pregnant at time of death Month Day Year 4 ☐ Pregnant a ed by the a been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Hospital or Attending Physician: The 1 Yes Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 Yes 2 1 No Other: ပ္ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin ☐ Accident ☐ Suicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie 29c. License number D 0064624 March 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walk Dr. Caithersbury, MD 20878

DHMH 17 Rev 7/2009

State Registrar 31. Date filed

Box (

743

32. Registrar's Signature

SHARMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 18ay **Physician** Jane L. Snelling Conner 2010 2310 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 17. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔽 F 215-28-7300 Aug. 89 1920 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Cec i 1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 244 Little New York Road 21911 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify <u>გ</u> Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, the Mar Elementary/Secondary (0-12)
Ten Years College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph C. Snelling Norma L. Ropka 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marjorie Tharp 244 Little New York Rd.. Rising Sun, Maryland 21911 (daughter) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/23/10 Port Deposit, Maryland Asbury Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, 21. Signature of Funeral Service Licenses Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final emelitic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed Mm131 physician and s the burial-trans resulting in death) Last Due to or as a consequence of) Box 68760, Physician/Medical attending pl IF FFMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) P.0. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law 24a. Was an certificate has autopsy performed 2 🗆 🌃 1 ☐ Yes 2 No 1 ☐ Yes After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

SWEWL

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

19110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Year CAMPBELL MARCH PAULINE 7:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death VILLA ROSA NURSING HOME MITCHELLVILLE PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🏝 Months Days Hours Min. JUNE 4 Yrs T930 WASHINGTON, DC Director 79 577-42-4660 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3800 LOTTSFORD VISTA ROAD 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: 3 Divorced 4 X Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CUSTODIAN GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM NAOMT BUCHANAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN A. CAMPBELL/SON 930 VILLAGE GREEN DRIVE LANDOVER, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/22/2010 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY LANDOVER, MARYLAND 21. Signature of Funeral Service Licer 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ADULT FAILURE TO THRIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 X No 2X No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🕅 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer Certificate: Natural 5 Pending 1 🗌 Yes 2 🗀 No Investigation Accident Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Sig

RICHARD FELDMAN M.D.

MAR 1 8 2010

D32261

8116 GOOD LUCK ROAD # 300 LANHAM, MARYLAND

MARCH

20706

16, 2010

10-02055 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Gregory Davis** 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gregory Davis 1613 hrs Medical Examiner March 12, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 511 Priscilla Street Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex Months Hours Director 135-46-5168 1 X M 57 NewyJersey 2 F 04 05 1952 Usual Residence of Decedent 10d. Inside City Limits ű 10b. County 10c. City, Town or Location 1 Yes 2 No "naturul", or items 23a or 28a-f shov Examiner must be notified at once. Maryland Wicomico Salisbury hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 511 Priscilla Street 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes Specify: Black 3 X Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: "natural", \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) it. Pages I and 2 should be filed within 72 hou. tent to ff heath and Mental Hygiene. Tant: If litem 27 is marked other them." Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) laborer none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nathaniel Davis Peggy Dashield 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Davis/daughter PO Box 606, Chadds Ford, PA 19317 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Family Cemetery 03 24 2010 Tyaskin, MD Donation 5 Other Specify 21. Signature of Funeral Service Life 22. Name and Address of Facility Stewart Funeral Home, 821West Rd., Salis., MD2180 Approximate Interval hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician en Onset and failure. List only one cause on each life /Medical Death Diabetic ketoacidosis Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit /sician/Medical AMENDED 23a,27, permE, g902 4/2/10 TT X UNPENDED ending physician use as the burial The law requires that the death certificate be Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the . 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 Yes 2 No 3 Probably 4 V Unknown page 2 should be Completed Records, 24b. Were autopsy findings available certificate has been 24a. Was an autopsy prior to completion of cause of performed death? ✓ Yes 2 No 2 No 1 🗸 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 5 Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be Homicide 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician:

Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (MMA Ra) 2°5° 2010 32 Registrar's Signatur

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 13, 2010

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

10-01426 Tyro

## Amend Item 12 per FH G901 3/31/10 dk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		4	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Eccation C	of Death		rince Georg	
		4	Prince George's Hospital Center	er 24Hrs. 8. D	ate of Birth(MM/D	DD/YYYY) 9. Bi	rthplace (State or gn Washington
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	any						10d. Inside City Limits
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With 12	18 23s		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic of the Paragraph (Culture Inc.)	gin? (Specify `n, Puerto Rican		14. Race - Ame White, etc.	rican Indian, Black,
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215- be filed	ked of	BeC	Sv1	lvia V.	Dade		to Zin Codo)
212 ould by	Ment mark		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Nu				t
A Z Sho	th and 27 is umat		Sylvia V. Dade / Mother 3700 9th Street SI	E #614_	Washingt	Location - City	20032 or Town, State
<b>.e</b>	Heal Fitem		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)				
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altimore, mit. Pages 1 a	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Licensee	"Alexano	der S. P	ope Fur	eral Home
			23a. Part). Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as	ia Ave cardiac or resp	SE Was piratory arrest, sh	ock, or heart	Approximate Interval 8 etween Onset and
	sician ledical		failure. List only one cause on each line.	nsis co	mplicat	ed by	Death
	aminer		failufe. List only or te cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cellulitis of the right leg & serior condition resulting in death)  Due to (or as a consequence of): narcotic (morphine)	e & met	hadone)	intoxi	ation
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		Examine	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):				
7	d d ansit	ŭ	events resulting in death) Last Due to (or as a consequence or).				
5	cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED 2.23a,27, per ME g902 4.6.10 T	T			
60,	ate be hysici e buri	Med	23c If yes outcome of pregnancy		2	3d. Date of deli Month	very Day Year
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Box	atten atten for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
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<b>5</b>	ling Physic After this funeral dir	2	27 Mapper of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at W		d. Describe how	injury occurred	
u C	ath ath r: Al	ţ	1 X Natural 5 Pending 1 Yes 2				Dural Davida Number City
Division	r Atte	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building	g, etc. 28	or Town, State	et and Number o	r Rural Route Number, City
ρi	urs af	Certification:	4 Homicide determined (Specify)				atatod
	To the Hospital or Attending Physician: The law requires that the death certiticate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and more and a fine than the fine and fine the property of the principle of the purial - transition and situation to the fine and fine the fine and fine the principle.	2 2	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	d place, and du h occurred at th	ie to the cause(s) ne time, date and	) and manner as I place, and due	to the cause(s)
	Fo the Fo the	ledical.	and planner stated. 29c License num		29	d. Date signed	(Month, Day, Year)
		2	29b. Signature and title of certifier.  O.C.M.E.		F	ebruary 18,	2010
			( was by aller Velet				
			30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 21	1201		
_			Victor vveeditivis as 7 to other	<del></del>			
	Reg	Stat istra			OCAJE		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** Florence Elliott 23.PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washing Halessawn ushun If Under Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 219-14-9811 84 Director June 1 1925 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12 S. Walnut Street, Apt.716 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: Completed by White 3 ☐ Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 <u>Homemaker</u> Her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Franklin Ahalt Ida Florence Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7825 McClellan Avenue, Boonsboro, Md. 21713

Page of Disposition (Name of Date 20c. Location - City or Town, State Ida M. Fincham - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 
☐ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rose Hill Cemetery 3/25/10 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OPD Immediate Cause (Final **Physician** obstructive sulmovery disease or condition resulting in death) Chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the buriaf-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an MOM autopsy performed?
Yes 20 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Medical Certification: To 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural after death.

I Director: Af in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours at To the Funeral C completely filled it Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

erstown Mr.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

3-22-2010

Physician   Phys													_	
Private Process Proces			٠	_ State	State of Ma					and Me		- 6	2010	09916
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DOUGH House Director	4.	/Medic	al					41. 01. 7			/arch			
Social Security Number   D. See   T. Age of the Property   S		Examin	er	, , ,	eet and number)								-	
215-34-1383   Table		Funeral			7. Age	e (In yrs. last birth	day)	If Under 1 Year	If Under 2		Date of Birt		9. Bi	rthplace (State or Foreign
Production   August Greenwalt   Section   Se		Director		215-34-1383	1 2 <b>7</b> F	74 Yr	s.	Months Days	Hours		ily 7,	193	5 Ma	
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State of Maryland / Department of Haalth and Mental Hygiene) 0 996 6  Certificate of Death Replace  Physician Replace  Frequency  Physician (Medical Exp. Text. of London of Death  Physician (Medical Exp. Text. of London of Death  Physician  Frequency  Dov. House  Science State of Maryland / Department of Haalth and Mental Hygiene) 2 12:08 p.M.  Physician  Frequency  Dov. House  Science State of Maryland / Department of Haalth and Mental Hygiene) 3 20,000 c. Carroll  The Comment of London of Death  Dov. House  Science State of Maryland / Department of Haalth and Mental Hygiene) 4 c. Curry of Death  Dov. House  Science State of Maryland / Department of Haalth and Mental Hygiene) 4 c. Curry of Death  The Comment of London of Death  Dov. House  Science State of Maryland / Department of Haalth and Mental Hygiene) 5 c. Curry of Death  The Comment of London														
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Production   August Greenwalt   Section   Se	·^	fter de	Fun	THE HEATTER STORES	Armed Forces?	10	13.	If Yes, specify Cub	an, Mexican	, Puerto Ric	an, etc.)			
Production   August Greenwalt   Section   Se	036	urs ai ai",oi	by		If Yes, Give			1∐Yes 2⊠No	Specify:				Specify:	White
Production   August Greenwalt   Section   Se	2-0	72 ho	eted	15. Decedent's Educa	ion	16a. D	ece Give	dent's Usual Occup	oation	t of working		16b. Ki	nd of Busines	s/Industry
Production   August Greenwalt   Section   Se	2	ithin ne.	mpl			+)			d)	or working				
State of Maryland / Department of Health and Mental Hyglene   0   0 9 9 6    Physical and Member Page   1   2   0   0   0   0   0   0   0   0   0														
State of Maryland / Department of Health and Mantal Hygiene) 0 0 9 9 1														
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The Boundary Concession of Supervision State (Section 1997)  The Boundary Concession of Supervision Supervision (Supervision Supervision S	S	nd 2 suith ar 27 is rtrau				1		-						
23a. Pp.nf-friter the disease, or complications they caused the death. Conditions are consequence of the conditions of	ē,	s 1 ar		20a. Method of Disposition										r Town, State
23a. Pp.nf-friter the disease, or complications they caused the death. Conditions are consequence of the conditions of	Ē	Page nent c int: if			noval from State				i	3/18/2	2010	Gamb	er. Ma	rvland
Physician Medical Examinor  Physician Medical Examinor  Frequency 1 and	a	portar portar y inju		21. Signature of Funeral Service Licensee		1120124	22	2. Name and Addre	ess of Facility	Þritts	s Fune	ral	Home &	Chapel. PA
23c.   Part Fetrate the deases, or completations, that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory areast, inference the deases, or completations, that caused the death. Do not enfort the mode of dying, such as cardiac or respiratory areast, inference the death of	<u> </u>	9 9 <b>2</b> 8 9		John 18			4:	l2 Washin	aton :	Rd. We	estmin	ster	MD	21157
Physician Medical Examiner    Part   Physician   Physi	Е			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused cause on each lir	the death. Do no	t en							Interval Between
Due to (or as a consequence of):    Due to (or as a consequence of):				Immediate Cause (Final disease or condition	Met	state	_	Dre	Me	$\mathcal{C}_{i}$	A			Onset and Death
The property of the part of th	. /			resulting in death)	Due to (or as	a consequence of	):							
An Section thereof the provided plant in the control of the contro														
Due to (or as a consequence of):  d.    IF FEMALE:   23c.   If yes, cultome of pregnancy   1		nsit	nin	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or,								
Section   Part	Ć.	execu in and ial-tra	Еха	that initiated events C.	Due to (or as	a consequence of	1:							
Second   S		te be ysicia e bur	<u></u>	L <sub>d.</sub>										
Second   S	89	rtifica ng ph as th	<b>Jedi</b>	IF FEMALE.	· · · · <u>-</u>									
DOVE HOUSE    Control   Co														
25. Was case referred to medical examiner?  1	ري ح	s that ned b		Part II. Other significant conditions contr	buting to death be	ut not resulting in t	he u	nderlying cause giv	en in Part I.		23e. Did t	tobacco u	ise contribute	to the cause of death?
25. Was case referred to medical examiner?  1	ğ	equire en sig ould b									1 🗆 '	Yes 2	<b>⊒</b> No 3□	Probably 4 ☐ Unknown
25. Was case referred to medical examiner?  1	ပ္ပ	law re as be 2 sho	plet										24b. Were	autopsy findings available
25. Was case referred to medical examiner?	<u> </u>	The ate h	Som								perfo	rmed?	1 death?	
State Registrar   State Regi	/ita	ician: sertific ector,		eyaminer?	24.1					of Death (	Check only o	one)	,	11
State Registrar   State Regi	ot	Physic this cal dire	7	1 162 5 140	1   Inpatie			IL 3 L DOA	4 LI Nu		•			becify) HOSH CE
296. Signatural and title of certifier  296. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Flavio Notes and 555 South Cata Mad Westminster, MD 21157  State Registrar  MAR 1 6 2010 Linear S. January  MAR 1 6 2010 Li	u O	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Da	y, Year) 280. Tir		Wor			d. Describe	how injur	y occurred	
296. Signatural and title of certifier  296. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Flavio Notes and 555 South Cata Mad Westminster, MD 21157  State Registrar  MAR 1 6 2010 Linear S. January  MAR 1 6 2010 Li	S	deatl deatl ctor: y the	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Init	urv - At home, farn	n. str		ites Z 🔲 i		Location (	Street an	d Number or i	Bural Boute Number
296. Signatural and title of certifier  296. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Flavio Notes and 555 South Cata Mad Westminster, MD 21157  State Registrar  MAR 1 6 2010 Linear S. January  MAR 1 6 2010 Li	2	al or / s after i Dire	erti	4 Homicide	building, etc	c. (Specify)	.,	,,,			City or To	wn, State	)	
296. Signatural and title of certifier  296. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Flavio Notes and 555 South Cata Mad Westminster, MD 21157  State Registrar  MAR 1 6 2010 Linear S. January  MAR 1 6 2010 Li		e Hospit 24 hours e Funera letely fille		(Check only 2 Medical Examine	<ul> <li>r: On the basis o</li> </ul>	f examination and	deat or ir	h occurred at the to estigation, in my	ime, date ar opinion, dea	nd place, an ath occurred	d due to the at the time,	cause(s , date and	) and manner d place, and d	as stated. ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Flavio Mark MD 555 Stuth Cata Mot West MIDSTER MD 21157  State Registrar  MAR 16 2010 Lenua S. Januar		<b>6</b> ₩ ₩ CO	Me	29b. Signature and title of certifier	uter	MD		29c. Licens	se number	R		29d. Da	te signed (Mo	nth, Day, Year)
State Registrar  Tlavic Note md 555 South (6 to Mot Westmuster, Md 21157)  32. Registrar's Signature  MAR 1 6 2010 Server S. January		, -		30. Name and address of person who com	pleted cause of d				1	h.				
		1 "			555 Sa	uth Ca	16	r Street	Was	thing	Ster 1	S QN	1157	
				, , , , , , , , , , , , , , , , , , , ,		ar's Signature		1		_	1-			
	DHI		-	MAR 1 6 20	110 Ken	wa B.	1	parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0420M 3 Mildre 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Dashing HSSISted avenwood Birthplace State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** Year) Months Days Hours 1 □ M 2 🔀 F Director 215-18-1456 88 28 1921 Maryland Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evention in the boddied at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1158 Luther Drive 21740 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be ပ္ Lewis Enos Leather Bertie Elizabeth Irving 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr once. Ann Wright - Niece 21118 San Mar Road, Boonsboro, MD. 21713 timore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beaver Creek Cemetery 3/24/10 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, MD. 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit U that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. 6 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

Name and address of person, ho completed cause of death (Item 23a) (Type, Print) WESOM MOSSER HURSPAN MOSTAN 32. Registrar's Signature

040602

-				epartment of Health and N	лental Hygie	ne 2010 00018	
			Registrar	Certificate of Death	Reg	.No. 2010 03310	
	Physician/ Modical Examiner  Physician/ Modical Examiner  To Decedent's Name (First, Middle, Last)  Physician/ Modical Examiner  Five Lyn Mary Frances Fridy  Evelyn Mary Frances Fridy  ### As Easily Name (if not institution, give street and number)  1705 Old Drummer Boy Lane  Fit. Washington  Fit. Washington  Fit. Washington  Fit. Washington  Fit. Washington  Frince George's  Fit. Washington  Frince George's  F						
	Total Content   Total Conten						
	Decederate Name Price According   Security News of personal programmes   Security News of pers						
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g. Birthplace (State or Foreign	
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	laryla 8a-f s tified	ect		Hope Mills		1 🏿 Yes 2 □ No	
	the h	٥			10g	. Citizen of What Country?	
	n with	nera	4437 Tonric Drive	28348		United States	
	deatl r iten iner n	Ē	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)		
38	al", o	d b	If Yes, Give	1 ☐ Yes 2 X No Specify:		Specify: African	
9	hours natur lical I	lete	15. Decedent's Education 16a. De	ecedent's Usual Occupation	16		
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Baltimore, Maryland 21215-0036	ntal H ed of	[일 [일	1	18. Mother's Nam			
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re,	1 and of Hear item		20a. Method of Disposition 20b. Place of Di	isposition (Name of			
Ē	Page nent c ant: If		Dullar 2 Diemation 3 Differiovariion State		25/2010 Ct	neltenham, Md.	
alt	ermit. epartr nport y inj						
ш		- 13	John J. Stewart, 44			gton, DC 20019	
			shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between	
4	nysician/ Medical	8 77	disease or condition Uterine Sarcoma			5 Months	
-	Examiner		Due to (or as a consequence of):				
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Box 687	ertifica ding p	/Me					
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Division of Vital Records, P.O.	that t ned b e deta		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?	
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<u> </u>	Phys this cral dir		1	atient 3 🗆 DOA   4 🗆 Nursing Ho			
o u	nding tth. ; After fune	cate	1 Natural 5 Pending (Month, Day, Year) inju	ry work?	200. Describe now i	njury occurred	
isio	Atter	# <u> </u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office			
<u>≤</u>	tal or irs aftr al Dir led in	S S	building, etc. (Specify)		City or Town, S	rate)	
	Hosp 24 hou Funer ted fil	dic					
	ithin 2 the omple	Ψ	only one) 3 Certifying Nurse Practioner: To the best of my knowled	ge, death occurred at the time, date and place	e, and due to the cau	ise(s) and manner as stated.	
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Al			Elizabeth K. Pfaffenroth, MD 1221		go, MD 2	0774	
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	Registra	ar	MULT O CAIR CONT.				

DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year

4b. City, Town, or Location of Death

FOSTER

2010

Black, White, etc.

4c. County of Death

MARCH

10:30 A

Birthplace (State or Foreign Country)

HAMPTON, VIRGINIA

Approximate Interval Between Onset and Death

Day

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2√ No

Month

1 TYes

GRAUS

Year

10d. Inside City Limits

1 XYes 2 No

**Physician** /Medical **Examiner Funeral Director** Director Funeral ρ

THOMAS

4a. Facility Name (If not institution, give street and number)

HYATTSVILLE PRINCE GEORGE'S ST. THOMAS MORE NURSING & REHAB If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1X M 2 □ F 78 JULY 11 1931 231-28-7854 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moderal Exprining must be realled at PRINCE GEORGE'S BOWIE MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1200 PENNYPACKER LANE 20781 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DELIVERY PERSON PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RICHARD FOSTER LAURA 2 NORFLET 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE FOSTER/WIFE 1200 PENNYPACKER LANE BOWIE, MARYLAND 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐ Removal 1 ☐ Burial 2 X Gremation rom State RIVERDALE CREMATORY 3/18/10 RIVERDALE, MARYLAND Donation 5 Officer (Specify) 22. Name and Address of Facility 21 Signature of Funer I Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Concer win Bra **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 TUnknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð INTOMERA BOILE he much 1 ☐ Yes 2 ☐ No Completed page 2 should in estastasis 24a. Was an autopsy this certificate 14yourtensian 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D000 1852 March 14 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Queensburg Ref Hyutter: 1/0 MD 20181

31. Date filed (Month, Day, Year) State MAR 182010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar	otato or maryian		tificate of i			Reg. No.	010	09	920
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	Year	3. Time of	Death
	Medic	al	4a. Facility Name (if not institution, give	Favors, Sr.					1 1 <sup>9ay</sup>		11:09	Ам
	Examin	er	Prince George's	,	er		or Location of Death ${ t heverly}$	1		nty of Death		1.0
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs.		th	9, Birth	George	r Foreian
	Director		410-64-40//	<b>⊠</b> M 2 □ F 71	Yrs.	Months Days	Hours Min.	May I	, Year) 1938	Te	nnesse	е
pu	show	5	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				Т	10d. Inside Cit	y Limits
Maryla	8a-f s tified	rect	Maryland Prince	George's		(	Capitol H	leights			1 🔀 Yes	-
the	a or 2 be no	Ö	10e. Street and Number	<u> </u>	_	10f. Zip Code	-		10g. Citizen	of What Cou	ntry?	
th wit	ns 23 must	Funeral Director	835 Balboa Aven				20743			Unite	d Stat	es
er dea	or iter niner	by Fu	11. Marital Status  1  Never Married 2  Married	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No	5. 13. V	Was Decedent of F f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerti	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White,		
UUS afte	rral", Exan	ed b	3 ⚠Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	1 ☐ Yes 2 🛣 No	Specify:		Spec		ican rican	
2 hou	"natu edica	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup	pation during most of wor	kina	16b. Kind o	f Business In		
within 7	than	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife. D	O NOT use retired) Mail				Govern	ment	
ied ×	Hygi other rent, t	Be	17. Father's Name (First, Middle, Last)				r	ne (First, Middle,				
yland Id be filed	Venta arked atic ev	٩		ur	ıknown			Kate	Polla:	rd		
shoul	and lis ms		19a. Informant's Name/Relationship (Ty	, . ,	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Towr	n, State, Zip	Code)	
and 2	Health		Floyd E. Favors,			Logwood	Rd. Car	oitol He			<del></del>	0743
10 age 1.3	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Dispo emetery, cren H ב	sition (Name of natory or other place armony lark	<sup>ce)</sup>   Ma;	rch 2010	20c. Locatio	-		
Dalumor	artme ortan injun		4 Donation 5 Other (Specification of Funeral Service Lises)		emoria	Name and Addre	ess of Facility S1		Land	over,	Maryla	nd
	any per		Many 10	A tous		4001 Ben	ning Rd.	NE Was	hingto	n, DC	20019	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory are	est,	7	Approximate Interval Betv	9
	ysician		Immediate Cause (Final disease or condition	Lung Can	cer						Onset and D	
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of ou tificate be executed	g physician and is the burial-transit	Medical Examiner		d								
Sertific 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal	ncy				224	Date of deliv		
JOX Jeath	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of d	ldeath 3 L eath 5 L	Ctopic pregnant Other (specify)	су			Month	-	'ear
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es tha	signed be de	þ	Part II. Other significant conditions co	ontributing to death but not resi	ulting in the u	inderlying cause gi	ven in Part I.				he cause of de	
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ne law	e has	Completed							rmed?	prior to co death?	psy findings a empletion of ca	use of
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VII	his ce I direc	일	T Li fes 2 LZFINO	Hospital: 1 🔼 Inpatient 2 🗆	ER/Outpatier	nt 3 🗆 DOA Oth	er: 4  Nursing H	lome 5  Resid	lence 6 🗆 C	ther (Specif	()	
o gu	offer the	ate:	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	ζ?	28d. Describe h	ow injury occ	urred		
or Attenc	ctor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		me farm stre		Yes 2 ☐ No	29f Lengtion /	through a seed \$1	- han an Diwa	I Davida Aliverti	
al or	s affer		4  Homicide determined	building, etc. (Specify)		sor, ractory, office		28f. Location (S City or Tow		riber or Hura	i Houte Numbe	зг,
lospit	t hour unera ed fille	Medical	29a. Certifier 1 X Certifying Phys	sician: To the best of my knowle ner: On the basis of examination	edge, death o	occured at the time	e, date and place, a	Ind due to the car	use(s) and ma	nner as state	ed.	
the H	thin 24 the F mplete	Me	anly and 3 _ Cortifying Nors	Proctionar: To the best of my	knowledge o	sieth cosumid at th	is time, date and pla	ice, and due to the	causs(s) and	manner as s	lated.	iner stated.
₽ 1	₹ 6 8		29b. Signature and title of certifier	71/		29c. Licens			29d. Date sig	ned (Month,	Day, Year)	
	4		30. Name and address of person who c	ompleted cause of death (Item	23a) (Tvn= =		69297		- 7/1	3/10		
·-	(			5 Greenway Cen	ter Dr		enbelt, l	Maryland	2077	0		
	Stat		31. Date filed (Month, Day, Year)	'32. Registra 's Sign	aled							
	Registra		MAR 1 8 2010 A	Le internal								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Year Maurice Gilbert 50 Medical March 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Collingswood Nursing Home Rockville Montgomerv Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Sex 1 M 2 □ F Months Min (Month, Day, Year) 09/10/1926 Hours Director 214-20-4480 Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start: If item 27.5 is marked other than "natural", or items 23a or 28a-f sho ury or orther traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Montgomery Rockvill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2001 Old Bridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced Specify. White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Life Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Abraham Goldberg</u> Anne Kluger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Gloria Gilbert / Wife</u> 12001Old Bridge Rd. Rockville, MD 20852 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Remembrance: 03/14/2010 Clarksburg, MD Ωf 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Lio nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Aspiration Pneumonia Medical resulting in death) Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 24 N 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural injury 5 Pending work 2 🗆 No 1 Tes 2 Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2 2

> State Registrar

completed

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifier

Sayed Elsayyad, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110 Molecular Drive, #206

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) March 12, 2010

Rockville, MD 20850

29c. License number

D62435

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milton March 15 Day 2010 Year Christopher Gelenian 1:20 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Feb. 28 Year) 1931 Wisconsin 391-26-0162 79 Director Usual Residence of Decedent show 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f s notified Maryland Montgomery Germantown 1 🗌 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 12128 Island View Circle 20874 within 72 hours after death with USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 □xYes 2 □ No If Yes, Give Ko Year or Dates. Co Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Korean Conflic Specify: White Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Merical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lawyer Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eghia Gelenian Siranoush Hartouinian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12128 Island View Circle, Germantown, MD 20874 Seda Gelenian/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Graceland Cemetery Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗷 Removal from State March 2010 Racine, Wisconsin 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer see Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spr Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiac Arrest minutes Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of performed? death? ☐ Yes 2 K No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🛚 No မ 1 🗌 Yes 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident 1 🔲 Yes 2 🗀 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 8 29d. Date signed (Month, Day, Year)

State Registrar VIPUL

9901

32. Registrar's Signature

Medical

Center Dr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KELLA

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 Year JERROLD EUGENE GILMORE 10:15 AM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days Hours Min. Director 23a or 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. o, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: marked other than "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) and Mental Hygiene. other traumatic event, Be 17. Father's Name (First, Middle, Last) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number permit. Page 1 and 2 st Department of Heath a Important: If item 27 is any injury or other tra Page 1 and 2 Collmore 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licerises 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final SYSTEMIC Physician. FUSARIUM disease or condition resulting in death) ONE MONTH Medical Due to (or as a consequence of) Examiner AILURE MARROW TWO MONTH Secure tinity list or inditional Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury MYELODYSPLASTIC SYNDROME Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi ADVANCED THREE MONTH that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by signe be c Records, 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 ☐ Yes 2 💢 No Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work' Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

24 hours after death. Funeral Director: A filled in by the completed

within 2 To the I

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a title of certifie 29d. Date signed (Month, Day, Year)

MD 037 394

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

NOUMAN ASIF

M, D

10 CENTER DRIVE. BETHESDA MD 20892

2010

State Registrar

Medical

31. Date filed (Month, Day, Year)

MAR

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Month Margie Margot Haag March 12 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. July 14. 75 Director 1934 Germany 244-78-4560 Usual Residence of Decedent "natural", or items 23a or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. You is marked other than "natural", or items 23a or 28a-f show ther traunatic event, the Melical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 100 Gardner Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (154 or 5+) Restaurant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Minna Glock ပ Friedrich Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 100 Gardner Drive, Annapolis, Maryland 21403 Joseph Haag, Jr. / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Kalas Crematory 3-13-2010 Edgewater, Maryland 4 Donation 21. Signature of Fur eral Service L 22. Name and Address of Facility George P. Kalas Funeral Home Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cell lung >mail Cancer disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed physician and s the bunal-transi Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 wonths?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed 24a. Was an page 2 s autopsy perform Yes or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Accident
Suicide 1 Yes 2 No Investigation 6 Could not be filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 29a Certifier сотріете 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier rance were, NO D52830

2973 Solomons Island Rd., Edgewater, MD 21037 Onset and Death 5 years 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No HOSPICE HUSC 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day. Year) March 12,2010 Jeanine Werner, MD, 900 Bestight Red #300, Amepolis, MD 21401 32. R gistrar's Signature ORIGINAL

7:50

9. Birthplace (State or Foreign

USA

Black, White, etc.

White

10d. Inside City Limits

1 Yes 2 X No

AM

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 1 5 2010

Ida Mae Henderso	1	- For State	State o	of Maryla		Depa	rtment o	f Hea	Ith an			/giene	Reg. No.	20	10	0992
Physician Medical Examine	1	1. Decedent's Name (First, I		AE HEN	DERS	ON						2. Date of De Month March 2:	eath Day	Year		3. Time of Death 0210 hrs
		4a. Facility Name (if not inst 4619 Rosedal Ave				om I		-	Town, or re de G	Location Frace	of Death		40	County of	Death	
Funeral	۲	5. Social Security Number	6. Sex	+ 5. F	7. Age (	In vrs. la	st birthday)		der 1 Yea		er 24Hrs.	8. Date of E	Birth(MM/	/DD/YYYYJaa	9. Birth	pplace (State or
Director	L	147–16–3074		м 2🗓 F		95		Mont					/19/	Ĩ	Foreign	
Ŷ.	-	Usual Residence of Decede  10a. State 10b. Cou			11/	Oc. City 1	Town or Local	tion								10d, Inside City Limits
<b>≹</b>		ARYLAND	,	FORD		oc. ony,	TOWN OF LOCA		VRE	DE G	RACE				ļ	1 Yes 2 No
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한 등리 때		3 X Widowed 4		1 Yes f Yes, Give Yes		No		Voc	2 <b>X</b> No	specify				Specify:	BLA	CK.
urs aft tural" amine		15. Decedent's Education	,	or Dates:		eted)	16a. Deceder					vork done	16b.	Kind of Busi		
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5-0036 led within 72 hour thygiene, other than "natu the Medical Example Commilered				1			L	AB T	ECHN	ICIA					ONIC	MANFACT.
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers.  Important: If item 27 is marked other than "natural?, or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Finneral Director		17. Father's Name (First, Mi UNKNOWN	ddle, Last)									(First, Middle	, Maiden	Surname)		
212 nould be in Ments is mark tic even		19a. Informant's Name/Rela	ionship (Ty	pe, Print )	_		19b. Mailin	g Addres	s (Stree			CAYLOR Rural Route N	umber, C	ity or Town,	State.	Zip Code)
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re, land F. Healt Fitem	ſ	20a. Method of Disposition  1 Burial 2 X Crem	otion 2	Domoval fr	am State		lace of Dispor			metery,		Date	20c.	Location - 0	City or 1	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	1	4 Donation 5 Other		Removarii	om state	'l	. FERR	IS &	co.	,INC	3/2	26/10	l v	EST (	HES	TER, PA
Salti ermit. epartn nport	T	21. Signature of Funeral Se	vice Licens	ee			22. 1	Name an	d Addres	s of Facili	ty TINE:	RAL HON	Æ. I	- Δ		
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Physician /M. dical		failure. List only one c	ause on eac	h line.							cardiac oi	r respiratory a	irrest, sn	ock, or near	ı O	Approximate Interval Between Onset and Death
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Of Ren		27. Manner of Death		28a. Date (Month	of Injury	ur)	28b. Time of	Injury	28c. Inju	ury at Wor	k?	28d. Describ	e how inj	ury occurre	d	
ion C trending leath. tor: Af			Pending Investigation		, Day, 1 oa	"			1	Yes 2	No					
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	ŀ	30. Name and address of pe	rson who co	ompleted cau	se of dea	ath (Item	23a)			-						
		Pamela E. Southa		Assistant				I1 Pen	n Stree	et, Baltir	nore, N	/ID 21201				
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ne Maryland or 28a-f sho notified at	Director	10a. State 10b. County  PA MD 10e. Street and Number	Harford	10c. City, Town or Edgewood	Location 10f. Zip Code			10g. Citizen of Wha	10d. Inside City Lim  1 🖾 Yes 2 🗆
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hear hear		19a. Informant's Name/Relationship (1) Rebecca A. Macklin 20a. Method of Disposition		405 20b. Place of Di	Bankert Roas	id, Hanover		per, City or Town, State  20c. Location - Ci	
Dallumore, permit. Page 1 and Department of Hee Important: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licen		Kenworthy	Funeral Hon 22. Name and Addr	ne, Inc. Marc ess of Facility	ch 14,201 26	Hanover,	PA Street
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Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Inten	э.	2	orrhage			Interval Between Onset and Death
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Attending Physician: The law requires that the death certificate be r death.  To death.  After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify) _	<u>'</u>		23d. Date o	
tha mec e de	by	Part II. Other significant conditions of	contributing to death b	out not resulting in th	ne underlying cause g	iven in Part I.	- 1		te to the cause of death?
Later Attending Physician: The law requires rs after death.  The law requires that death.  The funeral director, page 2 should be a proper to the funeral director.	Completed						per	opsy pric formed? dea	re autopsy findings availab rr to completion of cause of th? Yes 2 🗡 No
hysician: nis certific	To Be	25. Was case referred to medical examiner?  1 X Yes 2-3 No	Hospital:	ent 2 🗆 ER/Outpa	Tou	Place of Death (Chener: 4 \sum Nursing F		sidence 6 🗆 Other (	Specify)
To the Hospital or Attaching Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	ne	y, Year) injur	y M 1 L	rk? ☐ Yes 2 ☐ No		how injury occurred	
Hospital or A 24 hours after s Funeral Directed filled in by		4 ☐ Homicide determined	building, etc	c. (Specify)	street, factory, office		City or To	own, State)	r Rural Route Number,
To the Hos within 24 h To the Fun	Medical	(Check 2 L Medical Exam	niner: On the basis of e	xamination and/or in	vestigation, in my opin	ion, death occurred he time, date and plant	at the time, date ace, and due to	and place, and due to	the cause(s) and manner ster as stated.
WIL		30. Nam Bend achter 1 1en or Bees	Official cause of d	eath (Item 23a) (Tyn		643513149	189	3/11/	10
Stat		31. Date filed (Month, Day, Year)	3+1	ar's Signature	Crele	Breene 3	, Бал	7) 2/7	21201
Stat	e ir	MAR 17			parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Margie Medical Howsare March 17 11:59 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 103 Bentley Court Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, 1 🗌 M 2 ី F Days Hours Min Virginia Director 225-32-8780 80 Jan Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at. 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Bentley Court 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Manon Stoneberger Elsie Goode traumatic t. Page 1 and 2 should by thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Howsare/Husband 103 Bentley Ct., Hagerstown, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/22/2010 Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician BREAST Chucer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Donknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes \( 2 \sum \) No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D 68654 and address of person who completed cause of death (Item 23a) (Type, Print) THER 23a) (Type, Print)
THER IN HAGGESTOWN 129/16 CONAMIS DRIVE SUITE 2004
gnature
HAGGESTOWN, MD NOH-I mo

DHMH 17 Rev 7/2009

State

Registrar

Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ March 11 3:40 P. M Ann Madara Horton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Shady Gove Adventist Hospital Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours 200-34-4167 **Director** 92 Apri Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Watkins Mill Road 19301 20879 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work dane during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical 5+ Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Allen Madara Genevieve Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Warnaeke/Nephew 221 Booth Street #205, Gaithersburg, MD 20878 Baltimore, March 14 2010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place).
Georgetown University
Medical Center 20c. Location - City or Town, State Department of 1 Durial 2 Cremation 3 Removal from State Important: It any injury or Washington, D.C. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Rd., Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
3 DAYS shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease of linjury use as the burial-tran been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 RESPIRATORY FAILURE 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 2. ATRIAL FIBRILLATION 24a. Was an page 2 autopsy performed<sup>4</sup> death? this certificate 3. CONGESTIVE HEART FAILURE 2 No 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ္ 1 🗌 Yes 2 🔀 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No ☐ Accident Investigation filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. пpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the 29b. Signature and title of certifier D35941 M.0 MARCH 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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M.D.

32. Registrar's Signatu

ROCKVILLE

RESEARCH BLVD # 350

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Melitha W. Holbert 2010 11 1:20 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year Country) **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 06/02/ 1 🗆 M 2 🕱 F Min Yrs. Director 578-52-6781 69 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director DC Washington 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2827 27th Street NE 20018 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PHD College (1-4 or 5+) al Hygiene. Elementary/Seconday (0-12) Teacher DC. Public Schools of Health and Mental Hygi item 27 is marked othe other traumatic event, i Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wellesley S. Washington Earline M. Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 27th Street NE Washington DC 20018 Janice Taylor/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ò 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Mt.Olivet Cemet 4 ☐ Donation 5 ☐ Other (Specify) March20,10 Washington, DC 21. Signat f Funeral S e Licensee 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St. NWWash, DC 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause nat caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, neach line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Metastatic adenocarcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Renal failure Sequentially list conditions, ner if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the attending physician and ned for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Deep venous thrombosis that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Pregnant at time of death 5 Other (specify) Day 2 🛛 No detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 Yes 2 X No Yes 2 X No Be ( 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🔀 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending injury 2 Accident s after death. 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 20058063

State Registrar 1500 Forest Glen Rd. Silver Spring Md.20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

32. Registra s Signa

Dr.Kanwaljit Nagi

MAR 1 8 2010

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARCH 2010 Year 1:15 PM MAMIE HARRINGTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CLINTON PRINCE GEORGE'S FUTURE CARE PINEVIEW NURSING HOME If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 G Months AUG. 29 <sup>Year)</sup> 29 SOUTH CAROLINA Director 577-64-4157 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No PRINCE GEORGE'S CLINTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 9106 PINEVIEW LANE 20735 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 BLACK If Yes, Give 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE DOMESTIC 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARY ELLEN WILLIAM HARRINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUFFOLK AVENUE CAPITOL HEIGHTS, MARYLAND 20743 DICCIE M. JACKSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 3/25/2010 RESURRECTION CEME. CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME TA 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions Physician/Medical Examiner Due to (or as a consectuence of) cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? this certificate ☐ Yes 2X☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CL2 State

31. Date filed (Month, Day, Year)
MAR 1 8 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D050545

GODSWILL OKOJI M.D. 7513 NEW HAMPSHIRE AVENUE TAKOMA PARK, MARYLAND 20906

MARCH 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0993 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 9, 2010 8:15 Dorothy Jean Johnson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Home Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Towa Funeral 8. Date of Birth Year 19<u>21</u> 1 M 2 TXF Days Hours Month, Day, 88 Yrs. **Director** 478- 24-3766 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States <u>4925</u> Battery Lane #307 20814 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Flight Attendant</u> Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earle Johnson Martha Ostrem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lin Hamami/ Daughter <u>5601 Huntington Parkway, Bethesda, MD 20814</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 Removal from State permit, Page Department o Important: If any injury or FT. Lincoln Crematory 3/17/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease shock, of heart failure. Li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death ist only one cause on each line Immediate Cause (Final Ph sician/ NEUMONI disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjuly that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 1 Yes 2 K Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 😾 No Hospital: Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Ercertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar 2005 7124

, Rockville, MD 20850

3111110

o, mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao 10110 Molecular Drive # 206

	1	For State Registrar	State of	of Marylai		artment rtificate			and N	fental Hy	/giene Reg. No	601	0	09932	
		1. Decedent's Name (First, Middle, Last) 2.									. Date of Death			3. Time of Death	
Physiciar /Medica		Betty Mae Kramer					March 1					2, 2010 Year 6:30 P M			
Examine	-	4a. Facility Name (If not institution	ame (If not institution, give street and number)					4b. City, Town, or Location of Death				. County of	Death		
		14240 Triadelph	nia Road			Glenelg					H	Howard			
Funeral		*	6. Sex		. last birthday)	If Under Months	1 Year Davs	If Under Hours	24 Hrs. Min.	8. Date of Bi	av Year)		Counti	ace (State or Foreign	
Director		579-34-3352	1 □ M 2 1 □ F	80	Yrs.	Nonaio	Days	.,,,,,	1411111	02/24/	1930	W	ashi	ngton, DC	
2 P 3	- 1-	Usual Residence of Decedent  10a. State 10b. County		100.0	city, Town or Lo	nation							T <sub>10</sub>	d. Inside City Limits	
sho lary	. 1	MD Montgo	omery		orth Be		a						10	1 X Yes 2 □ No	
ク 'se F	i c	10e. Street and Number				10f. Zip	Codo				10a Cit	tizen of Wha	at Count		
rai", or Items 23a or 28a-1 show	by Funeral Director		T #1	022										•	
death	e e	5801 Nicholson		edent Ever in U	IS 13	20852 Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto			igin? (Sn	ecify Ves or N		nited States  14. Race - American Indian,			
ter d		1 ☐ Never Married 2X Marri	Armed F	orces?	5.0.	If Yes, spec	ify Cuba	in, Mexicar	n, Puerto	Rican, etc.)		Black, 1	White, et	c.	
D36	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1 □Yes 2	⊠ No	Specify:				Specify:	Whi	te	
21215-0036 d within 72 hours after giene. er than "natural", or Ite	Completed	15. Decedent	's Education	ation 16a. Decer			dent's Usual Occupation				16b. K	16b. Kind of Business/Industry			
	ed -	(Specify only highes Elementary/Secondary (0-12)		mpleted) (Give life. L			kind of work done during most of wor DO NOT use retired)			ing					
21 d with	Ş		4		Homem	aker						Own H	ome		
Set = E	ne ne	17. Father's Name (First, Middle, I	Last)				18. Mother's Nar			e (First, Middle	e, Maiden	iden Surname)			
yland	<u>-</u>	Paul Kerman						Lil1	ie F	Rose Sa	ndle	dler			
Aarylan 2 should be and Mental is marked or	1	19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rui	al Route Numi	ber, City o	or Town, St	ate, Zip (	Code)	
and and and and and and and and and and	1	Sidney Kramer-I	lusband		5801	Nicho:	Lson	Lane	<b>,</b> #1	1922 N	. Be	thesd	a, M	D 20852	
or H		20a. Method of Disposition 1   Burial 2 □ Cremation	2 Domewel from	20b.	Place of Dispo	sition (Nam natory or ot	e of her plac	e)	١	Date	20c. L	ocation - Ci	ty or Tow	n, State	
Pages ment of lant, If Its		4 □ Donation 5 □ Other (Sp			ıdean M	emoria	al G	dns 0	3/15	5/2010	01n	ey, M	ary1	and	
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event		21. Signature of Junera Service I	icensee	Molle	3 2	2. Name and	Addres	ss of Facilit	y Ędy	vard Sa	ge1	Funer	al D	irection,	
m #0=#9					_  1	nc. I	Rock	ville	, MI	le Pike 20852					
		shock, or heart failure. List	only one cause on							arrest,	est, Approximate Interval Betwood Onset and D				
Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Par	kinson'	's Dise	ase							4	Years	
/Medical Examiner		rooding in doding	Due to	(or as a conse	quence of):										
EFFECT :	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or se a conce	anence of:								_		
7 bear isist	Examiner	Cause (Disease or injury	Duc to	Due to (or as a consequence of):											
execu	X	that initiated events resulting in death) Last	c Due to	(or as a conse	quence of):					-					
(cate be executed physician and the burial-transit	dical														
	edic		U												
Box 6 eath certification attending properties as	completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, ou	itcome of pregr								23d. Date of	of deliver	v	
death death	20	in the past 12 months? 1 Yes 2 No	4 ☐ Preg	birth 2 Pet gnant at time of		⊒ Ectopic pr ⊒ Other <i>(sp</i> e		У				Month		Day Year	
cords, P.O. w requires that the di	n ys	9 Unknown	9 □ Unk	nown											
S, F	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause						cause given in Part I. 23e. Did tob					acco use contribute to the cause of death?		
ords requires een sign rould be	ed	Rheumatoid A	rthritis							10	1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Ur				
Records,	pier									24a. Was		24b. We	re autop	sy findings available	
The late has page	Ę			*						perf	opsy formed? 2 No	prio dea	or to com ath? ]Yes :	sy findings available upletion of cause of	
Vital Filclan: The certificate ector, pag		25. Was case referred to medical						26. Place	of Deat	1 ☐ Yes		7 1	Jies 4	2 🗆 140	
f V nyslc nis ce direc		examiner? 1 ☐ Yes 2 🏝 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DO	A Othe	er: 4 🗆 Nu	ursing Ho	ome 5 ☐ Res	sidence	6 XOther	Dau (Specify	ghter's Residence	
Division of Vital  or Attending Physician: The after death. Director: After this certificate tin by the funeral director, pa	1   Yes   2   No											Residence			
endii eath. or: A		2 ☐ Accident investig	ation	,,	1 '	M		Yes 2	No						
Visite of the contract of the		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Plac	e of Injury - At I	home, farm, str	reet, factory,	office			28f. Location City or To	(Street ar	nd Number	or Rural	Route Number,	
Ultal o	3														
Hosp 4 hou Fune tely fi	<u>g</u>	29a. Certifier    Checkoonly													
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Med	One)	and mai	nner stated.						1					
	-	29b. Signature and title of certifier					1504	e number 5				Date signed (Month, Day, Year) rch 13, 2010			
10	-	1100	0												
		30. Name and address of person					D2	***	1200	01	M	2002	2		
State		Philip G. Henji 31. Date filed (Month, Pay, Year)		.8109 Pa		птттр	חב1	.ve, #	200	OTHEY	, MD	2003	_		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, 28 F per ME g902 4/7/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DARCH 3:44 AM Harold William Loveless Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Aug. 18, 1942 1**火** M 2 □ F Marvland Director 67 213-40-7062 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17001 Burwood Court Lot 158 21740 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9 Construction Laborer be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Virginia Roherback Harry Edward Loveless, Sr. Mildred Page 1 and 2 should permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 Carol Loveless - Wife 17001 Burwood Ct. Lot 158 Hagerstown, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Mar.26,2010 Hagerstown, Maryland of Funeral Services Lice eborne AFtameraliy Home, P.A. Conococheague St.Williamsport,MD 21795 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Asphyxia Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed? Yes 2 N 21740 1 Yes 25. Was case referred to m lical examiner?
1 K Yes 2 □ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Accordantal abstruction 28c. Injury at work? March 21, 2010 wink 1 
Natural 5 Pending death. 2 💢 No Accident 1 Tes of thacheostomy tube due to position Investigation Director: completed filled in by the 6 Could not be Suicide 3 ☐ Suicide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

WASHINGTON County Hospital 28f. Location (Street and Number or Rural Route Number, City or Town, State 251 E. Antietam St determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 10-HO gistrar's Signature State Registrar

## Baltimore, Maryland 21215-0036

A.	Marie 111
ords, P.O. Box 68760,	aisol or Assonding Dhusision: The law requires that the death contificate he even that
3ecc	The law required th
n of Vital F	Dhusiolon
Division o	milen Assonding

		_	Type or Prin			i <mark>delible Ink.</mark> artment of H		•	_	
	•	For State Registrar		,		rtificate of L			g. No. 201	0 09934
Physicia	an	1. Decedent's Name (First, Middle, Las Helen Louise Love						2. Date of Death Month	Day Yea	3. Time of Death
/Medic		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death	March :	11 2010 4c. County of De	
		819 Lavale St.				Hagersto				on County
Funeral Director		5. Social Security Number 6. S 215-26-8744	ex 7. Age □M 2XTF	e (In yrs. Ii 80	ast birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth OCt. 23	,1929 Per	Birthplace (State or Foreign Country) Insylvania
		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or L	ocation				10d. Inside City Limits
Maryla -f sho	tor	Maryland Washingt	on County	,	ersto					1X Yes 2 □ No
or 28a	Direc	10e. Street and Number				10f. Zip Code			0g. Citizen of What	Country?
eath w	Funeral Director	819 Lavale St.	12. Was Decedent I	Ever in 11 S	S 13	21740			J.S.A.	merican Indian,
or iten	/ Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, W	hite, etc.
hours tural",	ed by	3 Nidowed 4 Divorced  15. Decedent's Ed	If Yes, Give Year or Dates:		16a Dec	edent's Usual Occup			16b. Kind of Busine	
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led wil Hygien her th		unknown			Home	naker	18. Mother's Name			Residence
ld be fi lental H ked ot Ic evel	To Be	17. Father's Name (First, Middle, Last) Harry Zimmerman					Mary Zin		naiden Surname)	
2 shou and M is mar aumat	_	19a. Informant's Name/Relationship (				ing Address (Street				e, Zip Code)
1 and Health em 27 ither tr		Carol Turner-dau  20a. Method of Disposition	ighter	20h P		Lavale St			21740 20c. Location - City	or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinating the rediffed at once.		1  Burial 2  Cremation 3  □ 4  Donation 5  □Other (Specif		Ce	emetery, cre	ematory or other place wn Mem. P	e)			n, Maryland
permit. Departm Importa any inju		21. Signature of Funeral Service Licer	•					1		neral Home
20 E # 9		23a. Part 1. Enter the disease, or com	TURY COUNTY	the death						, MD 21742 Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne.	Ari	est est	ig, such as cardiac	or respiratory and	531,	Interval Between Onset and Death
/Medical Examiner			Due to (or as	a consequ	uence of):	2S				
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):	10157				
be	<u>a</u>	resulting in death) Last	Due to or as	a consequ	ience of):					
tificate g phys as the l	edic	•	d							
ath cer ttendin or use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome			☐ Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
the deay y the a	Physician/Medic	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d	leath 5	Other (specify) _				Day You
N requires that the dobe been signed by the should be detached	by Pł	Part II. Other significant conditions of	contributing to death b	ut not resu	ulting in the	underlying cause giv	en in Part I.	23e. Did tol	15	e to the cause of death?
been s	eted	ATTOCK TO	Ormaty	OCY	-	. =		1 🗆 Ye	/ -	Probably 4 Unknown
sician: The law requires that the death certificate certificate been signed by the attending physi irector, page 2 should be detached for use as the	Completed	007011 (00)	le OC	72 13	ven	CK		24a. Was a autops perfori	sy prior med? deat	
clan:	Be C	25. Was case referred to medical examiner?						1 □ Yes th (Check only on		163 2 110
ding Physician: n. After this certific funeral director,		1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpati	ent 3 DOA Oth	4 □ Nursing H		ence 6 Other (5	Specify)
anding ath. or: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Year)	Injury	Wor	kí? Yes 2 □ No			
al or Atters after de l'Directo	Certification: To	3 Suicide 6 Could not b 4 Homicide determined				treet, factory, office		28f. Location (Si City or Town		r Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, I	ledical C		nysician: To the best niner: On the basis of and manner st	of examina						
To th withir To th comp	Me	29b. Signature and title of certifier	20000	1 sh	001	29c. Licens	se number	) 2	29d. Date signed (M	donth, Day, Year)
1H-2		30. Name and address of person who	nengha	leath (Item	n 23a) (Type	e, Print) Yali	cull no	ous Pon	1 Haz	WE (06 14 114)
Sta		31. Date filed (Month, Pay, Year)	32. Registr	ar's Signa	ture	· regi	( I 1 )	PONUA	it like	2174)
Registr	-		UIU Dries	ma ,	A. A	east.				. , , , ,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State of Maryland / Department of Health State Registrar AMEND#29 cperDVR, 3-17-10, BMW, McCrifficate of Death 09935 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Paula 5:05 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 2 / 05/1937 1 □ M 2 🗓 F Min. Months Days Hours Washington. 579-50-1930 Director Usual Residence of Decedent 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3403 Farthing Drive 20906 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 Divorced Specify: Completed White. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Charles E. Smith should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Director of Transportation Jewish Day School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Platt Cecelia Schroeder permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Farthing Drive, Silver Spring, Maryland 20906 Thomas J. Lee - Husband Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns:03/12/2010 | Olney, Maryland Conation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00209 1800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ a Idia pathic disease or condition ulmona Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burial physician s the burial Physician/Medical death certificate be 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No. 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Certificate: To After this 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 24 hours after death Funeral Director: A ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town. State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed To the 1 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie P23120 29d. Date signed (Month. Day, Year) M.D. WP. 18414. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greene Smeet Baltimore,

State Registrar

#101

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010

		•	for State Registrar	otato or mary.	Ce	ertificate of	Death		eg. No.	03330
	Physicia	an	1. Decedent's Name (First, Midd					2. Date of Deal	th _DayYear	3. Time of Death
	/Medic	al	DOMINIC	DWAYNE	LLOYD	T 41 63 T		MARCH	9 2010	5:55 A M
	Examin	er	4a. Facility Name (If not institution HOLY CROSS HO			SILVE	or Location of Death R SPRING		4c. County of Death MONTGOME	RY
	Funeral Director		5. Social Security Number NONE	6. Sex 7. Age (In )	yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day MARCH	Year) 9. Birth Cou 8 2010 MARY	place (State or Foreign ntry) LAND
	/land		Usual Residence of Decedent  10a. State 10b. County	у 10с.	City, Town or L	ocation				10d. Inside City Limits
	e Mar	ctor	MD PRINC	CE GEORGE'S	BOWIE					1 X Yes 2 No
	with th	Director	10e. Street and Number	A.C. CANCELLARY		10f. Zip Code	20		0g. Citizen of What Cou	ntry?
	Jeath v	Funeral	5116 ST. THOMA	12. Was Decedent Ever in	n U.S. 13	Was Decedent of H	∠ <b>U</b> Hispanic Origin? (Sp an, Mexican, Puerto		USA 14. Race - Ameri	can Indian.
036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be redified at	by	1 XNever Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 X No		Rican, etc.)	Black, White, Specify: BL.	
15-0	be filed within 72 ho ital Hygiene. d other than "natui event, in Medical	Completed	15. Decede (Specify only high	ent's Education est grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business/In	dustry
212	i withir giene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	NONE		a)		NONE	
ng	< <u></u> 5 5 6 6	Be C	17. Father's Name (First, Middle	e, Last)			18. Mother's Name	e (First, Middle, I	Maiden Surname)	
yla	should be filed wand Mental Hygies marked other tumatic event, In	2	DWAYNE LLOYD				CAMILLE			
Baltimore, Maryland 21215-0036	es 1 and 2 should b of Health and Ment I item 27 is marked r other traumatic e	0.5		D / MOTHER	5116	ST. THOM	AS SANCTU	JARY BOW	r, City or Town, State, Zij IE, MARYLAND	20720
nor	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Bemoval from State	cemetery, cre	osition (Name of ematory or other pla	ce) ¦		20c. Location - City or To	,
altin	permit. Pages Department of Important: If it any Injury or once.		4 ☐ Donation 5 ☐ Other (			E CREMATO  22. Name and Addre		and the second second second	RIVERDALE,M NKINS FUNER	
n	8 9 1 6 8	11 11	1 X. P. 1	7-hall	1				ER, MARYLAND	
			23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final	or complications that caused the dist only one cause on each line.			ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
100	Physician /Medical		disease or condition resulting in death)	a. HYPOPLA Due to (or as a cons		GS			1	
-	Examiner		Convention, the conditions	NO RENA		ION				
	ed sit	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con-		DA MAINE				
	execut al-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons		RA VALVE				
09/89	ficate be executed physician and s the burial-transit			d						
89 Y	ertifica ling ph e as th	Medical	IF FEMALE:							
O. Box	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of deliv Month	rery Day Year
7.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant condit	tions contributing to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to t	the cause of death?
Z	equires	ed b	PULMONARY HEM	IORRHAGE				1 □ Y	es 2 <b>X</b> No 3□ Pro	bably 4 🗆 Unknown
Hec	The lay	Completed	PNEUMOTHORAX					24a. Was a autops perfor 1 □ Yes	med? prior to co	opsy findings available ompletion of cause of
VIta	ding Physician: h. After this certific funeral director,	Be (	25. Was case referred to medica examiner?	al Hospital:		T Out	26. Place of Deat	h (Check only or	ne)	
0	Phys er this eral dir	.T	1 Yes 2 No 27. Manner of Death	1 K Inpatient 2 28a. Date of Injury	2 ER/Outpatie	III J DOA			ence 6 Other (Speci	ify)
0	ath. rr. Afte	atior	1 Natural 5 ☐ Pendi 2 ☐ Accident invest		r) Injury	of 28c. Inju Wor M 1 □	rḱ? ]Yes 2 □No		,,	
DIVISION	l or Atte after de Directo	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	d not be mined 28e. Place of Injury - A building, etc. (Sp	At home, farm, s ecify)	treet, factory, office		28f. Location (S Cify or Town	treet and Number or Run n, State)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certifica completely filled in by the funeral director, p	edical C	29a. Certifier 1 Certify  (Check only one) 2 Medica	ing Physician: To the best of my at Examiner: On the basis of exam and manner stated.	knowledge, dea	th occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the orred at the time, or	cause(s) and manner as late and place, and due t	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certific	er O 4		29c. Licens		1	29d. Date signed (Month,	
			1 tobic (	laste, MD		00	031317		03-09-	2010
R	_			n who completed cause of death (E. M.D. 400 WEST	7TH STR		ERICK, MAF	RYLAND 2	1701	
*	Sta Registr		31. Date filed (Month, Day, Year MAR 1 8 2010		grature			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death E Gund Physician/ 3:58A M Gray Livingston Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Hospice USbur bastal Wicomico If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min 05/15/1921 Scotland Director 216-64-4952 88 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 29a-f shw 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Wicomico Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Meadow Street Apt 105 21811 ted Kingdom Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ð 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Private 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Clerk MD Book Exchange Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alexander Gray Margaret Crosbie permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Kloetzli-Daughter 8245 Sea Biscuit Road Snow Hill, MD 21863 Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 3/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Doys Montgomery 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician D10 m disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day the g Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes ☐ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᇛ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/3=2 Cettunam WAR 31. Date filed (Month, Day, Year 32. Registra State MAR 1 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death i. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MCGINT Month 03 Day // 2010 CAROL 6:41 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOUS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Country) Year) 934 MARCH 17. Director 285-28-7255 75 OHIO Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director **MARYLAND OUEEN ANNE'S** 1 Yes 2X No STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 CHESAPEAKE DRIVE 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. ral", or iter 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc <u>ک</u> 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other th HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FENTON E. MOORE MARGARET SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD T. McGINTY/HUSBAND Department of Health Important: If item 27 any injury or other tr 1100 CHESAPEAKE DRIVE, STEVENSVILLE, MARYLAND 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State MARCH 17 HOLY CROSS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2010 CLEVELAND, OHIO . Signature of Funeral Service Licencee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 Will Erous M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ RESPIRATORT FAILURE disease or condition resulting in death) ACUTE Medical Due to (or as a consequence of): Examiner CARDIAC ARREST Sequentially list conditions, Examiner Duki to for selections equipment of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed OBSTRUCTIVE ChRONIC PULMONARY DISERSE the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical CONGESTIVE MEART FAIME Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Tobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? this certificate 2 No Yes 2 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 216 Certificate: To 1 🗌 Yes 1 Inpatient 2 RER/Outpatient 3 IDOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred : After 1 Natural 5 Pending Investigation
6 Could not be 1 🗀 Yes 2 🗆 No \$ hours after death uneral Director: / Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of ertifier 29d. Date signed (Month. Dav. Year) D0062349 03 12 2010 de

Registrar DHMH 17 Rev 7/2009

State

7002 MEDICAL PARKWAY # 070 ANDAPOUS MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW MCGLONE

MAR 1 5 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Year APHNE FLEMING OYCE MENCARIM 03 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 F Months Hours (Month, Day, Year) 01/18/1929 Director 81 Maryland 578-30-6002 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 🗌 Yes 2 ី No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 923 Riversedge Circle 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify 3 √ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 t. Page 1 and 2 should be filed wit thent of Health and Mental Hygie rtant: If item 27 is marked other i jury or other traumatic event, th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estes Fleming Sue Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1921 Batten Hollow Road, Vienna, VA 22182-1916 Steven J. Mencarini / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 03/15/2010 | Edgewater, Maryland 21. Sign y Ann I S he Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗆 No Yes 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred injury work? 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print) EXENSE HIGHWAY ANNAPOLIS MOLIKUI mp 32. Registrar's Signature MAR 1 5 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year AM 0957 Betty Wanetta MOWEN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕅 F Days Hours Min July 10 Pennsylvania 86 Director 1923 219-14-8279 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 17023 Allison Avenue 21795 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 X Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify White 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic managements. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker <u>Her own home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond R. Fridinger Mary Elizabeth Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Mowen - Husband 17023 Allison Avenue, Williamsport, Md. 21795 Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 3/25/10 Williamsport, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events (or as a consequence of) Exami Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed | 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 2 🗌 No Yes 2 IN 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 1 No မ 1 Yes 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a, Certifier 1 🗏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Physician in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie D5826

State

Registrar

Medical

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For Figure 19 Properties 19 Pr Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Jeanne B. Moulton Marchin 16. 2010 Year 4:45 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3126 Gracefield Road, Apt. 212 Silver Spring Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 14, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 89 79-32-91106 1 M 2 TX F Days Hours Min. Director Connecticut Usual Residence of Decedent 28a-f show 10h. County other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3126 Gracefield Road, Apt. 212 20904 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò δ Baltimore, Maryland 21215-0036 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 ☐xNo Specify: "natural", 3 Midowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မှ George Stuart Brady Adeline Constance Kelley 19a. Informant's Name/Relationship *(Type, Print)* Martha M. O'Hehir/Daughter 19b Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) 3139 Anchorage Drive, Annapolis, MD 21403 permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date March 19, 2010 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) entembrent Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Non-Small Cell Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death Month Day Year ed by the detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 ☐ No 3 🕱 Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed? death? certificate 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ρ 29c. License number 29d. Date signed (Month, Day, Year) D62234 March 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manish Agrawal, MD 9707 Medical Center Drive, #300, Rockville, MD 20850 31. Date filed (Month, Day, Year, State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ A M MGBEMENA CHIBUZO 2:24 MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE HOSPITAL ROCKVILLE 8. Date of Birth (Month, Day, ) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 19<u>35</u> 74 218-77-1509 NIGERIA Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Yes 2 No LAYTONSVILLE MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20882 Funeral 22309 BERTIE FARM COURT Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Rusiness Industry (Specify only highest grade completed) 2 should be filed within 72 is and Mental Hygiene.
7 is marked other than "in Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
ELIZABETH ADIMACHUKWU ၉ FRANK OJUKWU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health ar Important: If item 27 is any injury or other trau 22309 BERTIE FARM COURT LAYTONSVILLE, MARYLAND 20882 IFEOMA THOMPSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State FAMILY PLOT 5/5/2010 LAGOS, NIGERIA 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME Signature of Funeral Service Lity nsee 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARDIAC ARREST Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 XNo Month Day Year Pregnant at time of death g 🗌 Unknown sate has been signed by the spage 2 should be detached. g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 1 ☐ Yes 2X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2X No Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred e Hospital or Attending F 124 hours after death. e Funeral Director: After Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MARCH 7, 2010 D0059638 address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE ROCKVILLE, MARYLAND 20850 CHERIE TERRY M.D. 32. Registra 31. Date filed (Month, Day, Year) State MAR 1 8 2010 Registrar

10-02326 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Macie Madeline Moore State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day March 22, 2010 1945 hrs Medical Examiner Macie Madeline Moore c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Frederick Frederick Memorial Hospital **Frederick** 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Director 9/15/1941 Iroquois, 2 X F 68 1 M Yrs 453-96-7476 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 1 Yes 2 X No 28a-f shov narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. ore, MD 21215-0036 es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. WV Raleigh Hinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. ō 25951 1463 New River Road 14 Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. White, etc. Armed Forces? Never Married 2 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White 3 X Widowed ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eliza Smith A. L. Grose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) o. O. Box 895, Hinton, WV 25951 Doris Hickman / Sister If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Alexandria, Virginia 3/25/10 Metropolitan Crematory 4 Donation 5 Other Specify. 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Service Licensee Hyattsville, MD 20781 RANTROLANS Gasch's Funeral Home, PA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line **Medical** Death Fentanyl intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Records, P.O. Box 68760, The law requires that the death certificate be executed hysician/Medical signed by the attending physician be detached for use as the burial -XUNPENDED per ME #902 4/14/10 TT .28a-f. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a, Was an certificate has been prior to completion of cause of autopsy performed? Yes 2 ✔ No death? 2 No Yes page 1 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital 8 examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification Natural 1 Yes 2 X No Division Pending the 3/22/10 Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 90 Waverley Dr filled determined apartment (Specify) Frederick Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number

CA

State 31. Date filed (Month, Day, Year)
Registrar NAR 2 6 2010

Laron Locke MD.

32. Registrar's Signature

and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 23, 2010

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary C. 12:25 Pм Marr 2010 Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood At Crumland Farms Frederick Frederick 8. Date of Birth (Month, Pay, Year) May 19, 1923 . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director Pennsylvania 86 93-14-7340 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or the rail marked other than "natural" or the instance. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 7401 Willow Road 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Admini<u>strati</u>ve Assistant Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oscar Huber Christina Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Marr / Daughter 2006 Jefferson Pike, Knoxville, Maryland 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 30, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Calvary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Altoona, Pennsylvania 2010 Signature # Funeral Service Licens .22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 E. Church Street, Frederick, M MO1473 Maryland 21701 23a. Part . Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year Unknown signed by to be to be to be to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated bage 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page performed 2 X No Yes 2 💢 No 1 Tes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide injury 5 Pending Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 28 au 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) Dr Robert Kaufmann, 300 West Ninth Street, Frederick MD 21701 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			partment of Health and Itertificate of Death		20	10 09945
		Decedent's Name (First, Middle, Last)	Orimodic or Bodin	2. Date of Dea	th	3. Time of Death
Physici /Medic		Noel C. McDonald,	Jr.	March		Year 10 1248 P M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of	
<i>-</i>		Union Hospital	E1kton		Cec	i1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdt	Months Days Hours Min	8. Date of Birth (Month, Day NOV 23,	Year)	Birthplace (State or Foreign Country)
Director		199-34-6924		NOV 23,	1945 I	Pennsylvania
/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Man B-f sh	tor	Maryland Cecil Elkto	n			1 <b>X</b> 1Yes 2□No
th the or 28	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of WI	hat Country?
23a	ral	102 Hollingsworth Manor	21921		United	l States
er dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race	- American Indian, . White, etc.
s afte	by F	1  Never Married 2  Married	1 ☐ Yes 2 X No Specify:		Specify:	
hours a	be		cedent's Usual Occupation		16b. Kind of Bus	White
in 72 min	plet	(Specify only highest grade completed) (G.	ve kind of work done during most of work o. DO NOT use retired)	king	TOD. TAING OF DOO	inioss/industry
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2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 18 should have other than "natural", or items 23a or 28a-f show raumatic event, the Madical Examinating at the redified at	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, I	Maiden Surname	)
y d	٩	Noel C. McDonald, Sr.		e Rossi		
Viai 12 sh h and 7 is m rraum			illing Address (Street and Number or Rui			State, Zip Code)
T, I			Hollingsworth Man			21921
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the rediffied all once.		I Dourlai 2 Est Cremation 3 Li hemova iron 3tate	rematory`or other place) Marc	h 29,	zuc. Location - C	City or Town, State
artme		4 □ Donation 5 □ Other (Specify) Lawn Cro	oft Crematory 2010	<u> </u>	Linwo	od, PA
Depariment of the concession o			22. Name and Address of Facility Hicks Home for Fund 103 W. Stockton Sta	erals, P	.A. ktop MT	21921
	0	23a. Part 1. Enter the disease, or complications that caused the death. Do not				Approximate
Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	for duto	tan a a ser	On P	Interval Between Onset and Death
/Medical		disease or condition resulting in death)  a.   Due to (or as a consequence of):	, levi der to	present.	1	•
Examiner		Sequentially list conditions. b. all no new	Luler	181 		
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying				
xecut and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence of):				
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ifficate g phy as the	edic	d				
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death	□ <b>□ □ □ □ □ □ □ □ □ □</b>		23d. Date	of delivery
e deal	sicia	1 Yes 2 No	B ☐ Ectopic pregnancy □ Other (specify)		Mont	th Day Year
at the ded by the etached	Phy	9 🗆 OUKHOWH				
es the	ğ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			oute to the cause of death?
w requir s been s should	eted	Type that		1 □ Ye	s 2 □ No 3	Probably Unknown
e has	Completed	Chic anser		24a. Was ar autops perforn	n 24b. We y pri	ere autopsy findings available for to completion of cause of eath?
ician; The I certificate ha rector, page		25. Was case referred to medical	- /	1 ☐ Yes 2	No 1	Yes 2 □ No
	e Be	examiner?  1   Yes   2   No	26. Place of Deat			
ding Phys	n: 70	27. Many er of Death 28a. Date of Injury 28b. Time	of 28c, Injury at	ome 5 Reside		
Attending or death. ector: After by the funer	atio	1 Detural 5 Dending (Month, Day, Year) Injury 2 Accident investigation Injury	Work? M 1 □Yes 2 □No			
r Atte ter de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St. City or Town	reet and Number	or Rural Route Number,
urs af		~				
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cared at the time, da	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
o the ithin ( o the omple	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29	9d Date signed	(Month, Day, Year)
FSF5		Ancesta MD	D04823		2   9	1 1 12
	-	30. Name and address of person who completed cause of death (Item 23a) (Typ.	Print)		7/20	710
		JUI CHIH HEN MD 223 W	'est mon et.	FILCHO	- Md	21921
Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	w. J			
Registra	T.	mm 0 - 2010 peropio p. g.				

OHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I tem 9 per DVR G901 3/31/10 dk

State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month William 820 McLaughlin Sr. Jonah Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegan WMHS-RMC Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Ye Nov 13 1 QM 2 🗆 F Hours Min. Country) Director <del>217-30-1483</del> 80 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 10d. Inside City Limits Allegany MD Oldtown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 22514 Cedarbrick Lane SE 21555 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Korea white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) laborer PPG Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Estel K. (Jack) McLaughlin permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Ruth (Hose) McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22514 Cedarbrick Lane Oldtown MD Wilda McLaughlin wife MD 21555 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oldtown Cemetery 3/17/2010 Oldtown MD 21. Signature of Funeral Series Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Fert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Shouls Immediate Cause (Final Ph sician/ STROKE HEMORRHAGIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe this certificate Yes completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mam 1 ann mi D0025406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2501 WILLOWBROOK RD CLUMBERLAND, MD ZISOZ WILLIAM LAMM MD 31. Date filed (Month, Day, Year) **NAR 3 1 2010** State arke Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Murrill Edward Noland, Jr. March 16, 2010 5:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 800 Cindy Lane Westminster Carroll If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, NOV 27, Birthplace (State or Foreign
Country) **Funeral** 1 M 2 □ F 213-58-2557 59 Nov 1950 Maryland Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Director Maryland Carroll Westminster 1 ☐ Yes 2 XNo with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 800 Cindy Lane 21157 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after de. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Experiment once. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Engineering Engineer Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Murrill Edward Noland, Sr Mary Elizabeth Wetzelberger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie M. Noland, wife 800 Cindy Lane, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗶 Removal from State 3/18/2010 4 Donation 5 ☐ Other (Specify) Medcure, Inc. Orlando, FL Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical pancieatic **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year signed by the and be detached for 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Hunknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No 1 🗌 Yes 3 Probably 4 Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 M Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated PROF 29c. License number MIL 164 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 119948 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 12:00 P.M March 2010 Lola Jane Norem /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Layhill Center-Genesis Eldercare Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖾 F Months Davs Hours Min 87 Director 468-24-5926 June 17, 1922 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once. 1 ☐ Yes 2 No Directo Silver Spring Marvland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 4221 Isbell Street Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Cornelius Wah1 Engler Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4221 Isbell Street, Silver Spring, Maryland 20906 LeRoy K. Norem/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Arlington Nat. Cem. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Rheumatoid Arthritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Pernicious Anemia and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical Chronic Anemia If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) ☐Yes 2K No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Generalized Muscle Weakness, Failure to Thrive, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Hypothyroidism, Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 □Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical To the P within 2 To the P and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H67624 16/10 ulden D.O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13718 Shannon Avenue, Laurel, Maryland 20707 Sultana Afrooz, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2010 Physician/ 5:10 P M Anne Post Orleans March Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Suburban Hospital
Social Security Number 6. Sex <u>Bethesda</u> Montgomery If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 12/12/1920 Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) Funeral 1 □ M 2🛣 F Months Director 89 136-18-4549 Usual Residence of Decedent show 10d, Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No DC None Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 24th St. N.W. 20037 USA #615 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Public Relations permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other I any injury or other traumatic event, the Consultant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဨ Charles Post Dina Yankelevich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 10949 East Dale Lane Scottsdale, AZ 85262</u> Janis Brown / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2010 Crematory Falls Church, VA National 21. Signature of Funeral Service Lice 22 Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DSEU DOANEURYSM Records, 216HT FEMORAL 2 No 3 □ Probably 4 □ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Auge Urleaus Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) LOUN 3112110

Registrar DHMH 17 Rev 7/2009

State

0

#206 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Truong Bao MD 10110 Molecular Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2010 05:00 PM Francis Anthony Ogonowski AKA Frank Anthony Ogonowski March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil Union Hospital of Cecil County E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Countryon, Island New York **Funeral** (Month, Day, av 29, 1 📉 M 2 🗆 F Months Days Hours Min Director 21-20-3937 76 May Usual Residence of Decedent 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? and Mental Hygjene. is marked other than "natural", or items 23a or aum: tic event, the Medical Examiner must be i Funeral with 199 Bethel Church Road 21901 United States Aswonop 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. ģ 1 Never Married 2 X Married 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stella Spychala 9 Anthony Ogonowski injury or other traumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 199 Bethel Church Road, North East, Maryland 21901 Patricia Ogonowski / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Marchate 22. cametery crematory or other place Delaware veterans Memorial Cemetery 1 🖺 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bear, Delaware 21. Signature of Furger 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on Immediate Cause (Final Onset and Death Physician/ yocard Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has , page 2 s autopsy performed? Yes 2 No certificate 2 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After s after dea. ral Director: Afte rv the fv | X Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the Funeral Directory filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year, W00564 O. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/00/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2010 Physician Annie Geneva Parker 11:30P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apex Nursing Home Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 / 28 / 1923 9. Birthplace (State or Foreign **Funeral** Months Days Hours Carolina Carolina Director 578-26-2241 86 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No MD Prince George Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4307 29th Street 20712 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: ģ Specify: Black 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Supreme Court Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev George Brunson Mamie Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlie Parker, III / Son 4307 29th St. Mt. Rainer, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Quantico National 3/16/10 4 ☐ Donation 5 ☐ Other (Specify) Triangle, VA 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerolic **Physician** ardiovasiman unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ neumomia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural 2 Accident 5 Pending investigation neral Director: / 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af 29a. Certifier 🚶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

wowde

Year)

30. Name and address of person wh (cor pleted cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

CHONDIHURY, MD: 15216 DINO DRIVE; BURTONSVILLE, MD 20866

D43121

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March Hazel Irene PLANK 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney Keedy Home Boonsboro Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Director 214-09-2889 92 Sept. 12 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 8507 Mapleville Road Funeral or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 📉 No Specify <u>\$</u> Specify: 3 Widowed 4 NDivorced 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 0 - 12<u>Assistant Manager</u> Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Geist ပ Mattie S. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronce. - Niece Carolyn Carter 1009 Salem Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/24/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a sonsequence of). use as the burial-trar resulting in death) Last law requires that the death certificate be exe Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **D**No Day Year 5 ☐ Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate ha performed' 1 □Yes 1 ☐ Yes 2 🗆 No 2 4 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 12 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

VH-4

Maryland 21215-0036

Baltimore,

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Records,

Vital

Division of

State Registrar

Cantone Vincent Α. 31. Date filed (Month, Dav. Year)

MAR 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

13424 Pennsylvania

29c. License number

29d. Date signed (Month, Day, Year)

Avenue, Suite 205, Hagerstown, MD.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			For State Registrar	State of Ma	aryiano /		tificate of t	Health and I Death		giene Reg. No	2010	09953
	Physicia	ın/	1. Decedent's Name (First, Middle, La JAMES	R. PETTUS	TD				2. Date of De Month	Da	Year Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give		JR.		4b. City, Town, o	r Location of Death	MARC		. County of Death	8:01 A M
			PRINCE GEORGE'				CHEVERL			P	RINCE GE	ORGE'S
	Funeral Director			Sex 7. Age	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da MAY 31	th ly, Year) 194	Cour	place (State or Foreign stry) INGTON, DC
	yland •f show ed at	tor	10a. State 10b. County		10c. City, Tov	vn or Loc	eation					10d. Inside City Limits
	e Mar r 28a- notifi	Director	MD PRINCE  10e. Street and Number	GEORGE'S	HYA	ATTS	VILLE					1 🕅 Yes 2 🗌 No
	/ith th		8013 BARLOWE RC	ΔD			10f. Zip Code 2078!	;		10g. Ci	tizen of What Cour	ntry?
	eath v tems er mu	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		14. Race - Americ	can Indian,
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 1  If Yes, Give Year or Dates.	N <b>A</b> RMY	- 1	Yes, specify Cuba		Rican, etc.)		Black, White, Specify: BLA	
15-0	72 hou n "nati ledica	Completed	15. Decedent's (Specify only highest g		168	(Give k	ent's Usual Occup ind of work done	ation during most of worl	king	16b. K	and of Business In	dustry
212	within glene. er tha , the N		Elementary/Seconday (0-12) 12TH	College (1-4 or 5			) NOT use retired) <b>Efeur</b>				GOVERNME	NT
pue	e filed htal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan			Surname)	20
چ	ould b nd Mer mark imatic	-	JAMES R. PETTUS  19a. Informant's Name/Relationship (		1 10	h Mailin	a Addraga (Straat		MAE EAR		Town, State, Zip (	Codel
Ž.	nd 2 sh ealth ar m 27 is ier trau		CAROLYN PETTUS								RYLAND 2	
Baltimore,	ge 1 ar at of Hu : If iter or oth		20a. Method of Disposition 1   ↑ Burial 2 ☐ Cremation 3 [	Removal from State	cemete	ery, crem	sition (Name of atory or other plac		Date		ocation - City or To	
Iţi	nit. Pa artmer ortant injury	1	4 Donation 5 Other (Special)		ARLIN	_	Name and Addre		/2010 J. B.		INGTON, VI	
B	permil Depar Impor any in	0	THE 1					OVER ROA				20785
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each line.	i and		-			rest,		Approximate Interval Between
	Pnysician/ Medical	Ŷ	Immediate Cause (Final disease or condition resulting in death)	a. Hepata  Due to (or as a	consequence	<u>ua</u>	r Carc	choma			_	Onset and Death
	Examiner		Sequentially list conditions,	Circh	WS15	of	the	Liver				
	od sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	ot).						
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. HCV  Due to (or as a	consequence	of):						
220	icate be executed physician and sthe burial-transit	lical	· ·	d								
387	ertifical ding ph	/Me	IF FEMALE:	23c. If yes, outcome of	of prognancy							
P.O. Box 68	death certificate attending properties as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal deal		Ectopic pregnand Other (specify)	у			23d. Date of delive Month	Day Year
0	hat the ed by t detach	by Phy	Part II. Other significant conditions	contributing to death bu	rt not resulting	in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco u	use contribute to th	ne cause of death?
ds, l	quires t en sign uld be	ted b	COPD	10.	,				1 🗆 🕆	Yes 2	□ No 3 □ Prot	pably 4 X Unknown
ecor	ie law rec e has bei ige 2 sho	Completed	Chronic Re	nal tai	lure					osy rmed?	prior to con death?	osy findings available mpletion of cause of
<u>=</u>	an: Th	Be C	25. Was case referred to medical				26. PI	ace of Death (Chec	1  Yes	2 🔀 No	1 Yes	2 L <b>X</b> No
<u> </u>	hysici his cer il direc	မှ	examiner? 1  Yes 2 No		nt 2 KER/O		3 □ DOA Othe	er: 4  Nursing Ho	ome 5 - Resid	dence 6	Other (Specify,	)
on of	ending Physician: The Issath. pr: Affer this certificate ha he funeral director, page	Certificate:	27. Manner of Death  1 Natural 5 Pending  Accident Investigation			Time of injury	28c. Injury work M 1 🗆	rat ? Yes 2 □ No	28d. Describe h	ow injury	y occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a		3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		y - At home, fa (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tow		d Number or Rural	Route Number,
	ne Hospi in 24 hou ne Funer pleted fill	Medical	(Check 2 L Medical Exam	rsician: To the best of n iner: On the basis of ex- se Practioner: To the b	amination and/	or investig	gation, in my opinic	n, death occurred a	t the time, date a	nd place,	, and due to the cau	ise(s) and manner stated.
	Vith Coal		29b. Signature and title of certifier	1			29c. License	number		29d. Dat	te signed (Month, L	Day, Year)
Š	~		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type_Pr	<del>-</del>	267			1-10-1	U
R	2		Martin Du	ncan M	latter	Re	eed A	MC 6	900 G	eorg	zi ave	O Wash De
	Stat Registra	_	31. Date filed (Month, Day, Year)  NAR 1 8 2010	32. Registrar	's Signature	1				0	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 122 2010 10:00pm Joe Ann Mooney Hylton Roark Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton Elkton Union Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Days Hours Min 7-20-1940 234-62-6591 WV Director 69 Usual Residence of Decedent 10b. County 28a-f sho 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Cecil Elktora MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21921 100 Laurel Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: "natural" 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.

27 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rilda E. Moiser Orel Henry Mooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 1359 Elk Forest Rd., Elkton MD 21921 Sheila Doughten 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 3-17-2010 Oxford, PA 4 Donation 5 Other (Specify) Oxford Cemetery al Service Edward L. Collins Funeral 22. Name and Address of Facility Home, Inc., 86 Pine St., Oxford PA 19363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ alexal disease or condition resulting in death) nknown Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Tes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours after Funeral Direc 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 3.15.2010 D0023322

Registrar DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

Elhton MD21921.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DACHDEN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09955 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year SUSIE ANN ROMERO 10:20 PM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE"S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, MAY I 6 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Min. Year 946 63 231-80-8997 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S LANDOVER MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3416 DODGE PARK ROAD # 202 20785 IISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Black, White, etc. ģ Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: BLACK Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RECEPTIONIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLIE ROBERTSON EDITH WALLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FANCISCO ROMERO/HUSBAND 3416 DODGE PARK ROAD # 202 LANDOVER, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESSURRECTION CEME. 3/24/2010 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) RESPIRATORY ARREST Due to (or as a consequence of): HYPERTENSION S—uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): DIABETES MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical ျှ Certificate:

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-tran Division of Vital Records, P.O. Box 68760 as the attending use detached signed by pe nours after death.

neral Director: After the filled in by the funera

**Funeral** 

Director

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traumatic ever

Department of Health and 2 should be Department of Health and Menta Important if item 27 is marked any injury or other traumationones.

Ph sician/

Medical

Examiner

the Medical

Examiner must be notified at

with the Maryland

hours after death

72 than

filed

Baltimore, Maryland 21215-0036

•	u										
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	1 Live Birth 2 Fet	Sc. If yes, outcome of pregnancy  1									
art II. Other significant conditions	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e Did tobacco	use contribute to the cause of death?						
OBESITY											
ODEDITI	2X No 3 ☐ Probably 4 ☐ Unknown										
				24a. Was an	24b. Were autopsy findings available						
				autopsy performed?	prior to completion of cause of death?						
				1 ☐ Yes 2 👿							
5. Was case referred to medical examiner?											
1 ☐ Yes 2 ☐XNo	Hospital: 1 Inpatient 2 🔽	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Spe									
7. Manner of Death	28a. Date of injury	28b. Time of	28c. Injury at	28d. Describe how inju	ury occurred						
1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not		injury M	work? 1  Yes 2 No		•						
4 Homicide determine				. Location (Street and Number or Rural Route Number, City or Town, State)							
9a. Certifier 1 Certifying Pr	nysician: To the best of my know	ledge death occured a	at the time data and place	<u></u>							
ou. common A continuing in	Tysician. To the best of my know	loago, acam occured a	at the time, date and place,	and due to the cause(s) i	and manner as stated.						

24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D065367

CHEVERLY, MARYLAND

29d. Date signed (Month, Day, Year) MARCH 15, 2010

20785

29c. License number

State Registrar

To the within 70 the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

MAR 182010

MEHDI SATTARIAN M.D.

3001 HOSPITAL DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician KATIE ROGERS March 2:06 PM 201C /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Prince Regional Hospita Laurel durel George's Social Security Number ge (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye MARCH 12 9. Birthplace (State or Foreign Funeral Year 577-48-9527 1 ☐ M 2 🗓 F 83 Months Days Hours Min. SOUTH CAROLINA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notifled at 10d. Inside City Limits 1√Yes 2 No Director PRINCE GEORGE'S LAUREL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 USA 9000 BRIARCROFT CROSS # 323 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: BLACK 1 ☐ Yes 2 No þ Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER PRIVATE h and Mental Hygie 7 is marked other t 10TH17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o EMMA BLANDING AMOS GALLISHAW injury or other traumatic မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILHELMENIA JONES/DAUGHTER 9000 BRAIRCROFT CROSS #323 LAUREL, MARYLAND 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GEORGE WASHINGTON CEME. 3/19/10 ADELPHI, MARYLAND 21. Sing ture of Funeral Privice Line 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 5 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sep5is Due to or as a consequence of): /Medical Examiner neumonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No Completed 1 Yes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy perforr certificate 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, n 24 hours after death.

he Funeral Director: A
pletely filled in by the fi

within 24 ho To the Fun completely

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 1 8 2010

30. Name and odress of person who completed cause of dea h (Item 23a) (Type, Print) Tarak Reddy, MD Regional Laurel 32. Registrar's Signature

and manner stated.

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Hospital

D69090

29d. Date signed (Month, Day, Year)

7300 Van Dusen Road

Laurel MD 20707

March 15, 2010

10-02016 Dekevin Raspberry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		(	Certific	ate of L	Death			R	Reg. No	o.		
Physic		1. Decedent's Name (First, Mic	idle,Last)							2. Date of Dea	ath			3. Time of Death
Medical Exan	nine	DEKEVIN	R.	ASPBER	RY					Month March 11		0		1038 hrs
		4a. Facility Name (if not institu		umber)		4b.	City, Town, or	r Location o	of Death			c. County o		
		11709 S. Laurel Driv	/e				Laurel					Prince G	eorge	's
Funera		5. Social Security Number	6. Sex	7. Age (In y	yrs, last birt	hday)	If Under 1 Yea		er 24Hrs.	8. Date of Bi	rth(MN	A/DD/YYYY		hplace (State or
Directo	r	218-17-4163	1 XM 2 F	34		Yrs.	Months Day	ys Hours	Min.	JAN 2	25 1	1976	Cou	WASHINGTON
	1	Usual Residence of Decedent												DC
any		10a. State 10b. Count	у	10c.	City, Town	or Location								10d. Inside City Limits
br work	<u>ـ</u> ا	MD PRIN	CE GEORGE	's	LAU	REL								1 Yes 2 No
faryland 28a-f show	<del>8</del>	10e. Street and Number				11	Of. Zip Code			11	l0g. Ci	tizen of Wh	at Coun	try?
the Maryland 3a or 28a-f sho	Director	11700 00000	AUDEL DEL	7D 1/1	2		00700	2						
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ath v item	Funeral	1 X Never Married 2	Married Armed	orces?			specify Cuba					White		ari iridari, biacis,
ter de		3 Widowed 4 D	1 Yes livorced If Yes, Give Ye	2 X n	<b>N</b> O	1 - V	es 21 No	specify:				Specify:	D.	TACIZ
5-0036 led within 72 hours aft Tygiene. other than "natural"	<u>م</u>	45 Daniel Ed - 15 - 16	or Dates:		d) 16a.		Usual Occupa		kind of w	ork done	16b	Kind of Bus		LACK
2 hou	Completed	Elementary/Secondary (0-1)		1-4 or 5+)	<u> </u>		of working life							,
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d wit	<u>5</u>	17. Father's Name (First, Midd		LIKD	1_1	MIKLI	KLINLOK	18.Mother	s Name (	First, Middle,	Maider			
	BB (		PRERRY					BREN	JDA 9	SMITH				
2121 Mental Marked Marked	م ا	19a. Informant's Name/Relation			198	o. Mailing A	ddress (Stree				nber, (	City or Town	, State,	Zip Code) 20708
imore, MD 2 Pages I and 2 should ment of Health and N Heatth and N Fant: If item 27 is up or other traumatic		BRENDA SMITH	HILL/MOTH	ER	100									ARYLAND
e, h l and Health item		20a. Method of Disposition		2	0b. Place o	f Dispositio	n (Name of ce			Date		Location -		
DOT Bes l tt of l		1 Burial 2 X Cremati				ory or other			0/1	( (0010				
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other 21. Signature of Funeral Service			KIVEK		CREMATO							MARYLAND
Baltimo permit. Page Department of Important:		21. Signature of Funeral Service					ne and Address	-						AL HOME
	_	23a. Part I. Enter the disease,	or complications that	caused the de	eath Do no		74 LANI							D 20785 Approximate Interval
Physiciar /Medica		failure. List only one caus	e on each line.				node or dying,	, such as co	ardiac or	respiratory arr	est, sii	lock, or riea		Between Onset and
Examine		Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wound of Head  Due to (or as a consequence of):									Death			
		or condition resulting in death)	Due to (or as	a consequen	ce of):									
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequen	ce of):									
	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	θ _											
d sit	×ai	events resulting in death) Las		a consequen	ce of):									
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be ex sician urial	/Medical	UNPENDED	AMENDED											
760, ficate be a physicial the buria	ĮŠ	IF FEMALE: 23b. Was decedent pregnant in		outcome of p	oregnancy	_					23	d. Date of o		
	l ä	past 12 months?		birth nant at time o	of death -			Ectopic	pregnan	су		Month	Da	ay Year
Box 68 death certif he attending d for use as	1 0	1 Yes 2 No 9 U	nknown 9 Unkr		ordeath 5	Other	(Specify)							
D. B. the de ched f	P.	Part II. Other significant cond	- (		not resulting	in the und	erlying cause o	niven in Par	rt I.	23e. Did to	bacco	use contrib	oute to th	ne cause of death?
F, P.O. ires that the signed by dedetached	è									1 Yes	2	/ No 3	Proba	ably 4 Unknown
daire quire uld b	ompleted	-								24a, Was				opsy findings available
cords, law requir has been s	월									autop	sy	pr	ior to co	mpletion of cause of
Rec The 1 cate b	l e									1 Yes	rmed? 2 \ N		eath? ✔ Yes	2 No
tal Fisian: Certific ector, 1	1 6	25. Was case referred to medic						of Death (	Check or	nly one)				
of Vital Records, ng Physician: The law require Mitter this certificate has been simple the should director, page 2 should be	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Ou	tpatient 3	_ DOA	Other4	Nursing	Home 5	Reside	ence 6 🗸	Other	Scene
n of ding Ph. After t	=	27. Manner of Death	28a. Date	of Injury		ime of Injur	y 28c. Inju	ry at Work?		8d. Describe I			d	-
Division tal or Attendiirs after death.			iding Ban 11	Day,Year) : 2010	FOU 1029		1 1	Yes 2	No S	ubject sho	t seir			
/iSi r Att ter de rirect	ertificati		vougation .				actory, office b	ouilding, etc						al Route Number, City
Division ospital or Attend hours after death nneral Director:	erti	4 Homicide		Multi-Fa	mily Apt				1	or Town, S 1709 S. Laur	tate) rel Dri	ve, Laurel	, MD	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	lo	29a, Certifier 1 Certifying	Physician: To the be											
To the Howithin 24 h	ledical	one) 2 Medical Ex	aminer: On the basis	of examination	on and/or in	vestigation	, in my opinion	, death occ	urred at	the time, date	and pla	ace, and du	e to the	cause(s)
5 7 8 5 8	Ne N	29b. Signature and title of certif	and manner : ier	nateu			29c. Licens	e number			29d.	Date signe	d (Mont	h, Day, Year)
		6.1.6.	1 mi	0			O.C.I	M.E.			Mai	rch 12, 2	010	
1 7		30. Name and address of person	n who completed care	se of death (	Item 23a)									
LX			ant Medical Exa	-		Street.	Baltimore, I	MD 2120	01					
	tata	31. Date filed (Month, Day, Year	,	egistr s Sig										
Regis		MADE OF A DEPTH	Clean	A. 1	A COLUMN TO THE PARTY OF THE PA									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Howard Bernard Souders, Sr. Physician/ March 2:30 Zolo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington County Hagerstown If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. . Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1XXM 2 | F 220-28-3764 76 **Director** Usual Residence of Decedent 28a-f show ge 1 and 2 should be filed within 72 hours after death with the Maryland rt of Health and Mental Hyglene. It flew T27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medica Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Co. Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17722 Red Oak Drive 21740 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1952 Armed Forces? 1 Never Married 2 X Married XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give 3 Divorced 4 Divorced to 1968 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Truck Mfg. Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nathan Jesse Souders, Sr. Catherine Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth H. Souders/ Wife 17722 Red Oak Drive, Hagerstown, MD 21740 20b. Place of Disposition (Name of cametery, crematory or other place)
Cedar Lawn Mem. Park Mar. 23, 2010 Hagerstown, Maryland 20a. Method of Disposition permit. Page 1 a Department of I Important: If ite any injury or ot 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, MD 21742 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final accident Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying ending physician and use as the burial-transit Cause (Disease or iiniun that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Pregnant at time of death s been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 performed 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and til March 18, 2010. cause of death (Item 23a) (Type, Frint) Boonsboro MD SHSTI 31. Date filed (Mor

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 0

		1	For State Registrar	State of Ma	rylanc		artment of I tificate of I		and M		giene Reg. No.	2010	09959
	Physicia		Decedent's Name (First, Middle, Last)     Harry Lee Sand							2. Date of De Month March		2010 Year	3. Time of Death 12:35 P M
	Medic Examir		4a. Facility Name (if not institution, give s				4b. City, Town, o	r Location	of Death	Harch		County of Deal	
			Casey House				Rockv					ontgome	
	Funeral Director			TM 2 DE	in yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Bird Jun . U	1 Year) 9	46 9. Bir	thplace (State or Foreign untry) I11inois
	land show dat	tor	Usual Residence of Decedent  10a. State  10b. County	·	10c. City,	Town or Loc	ation						10d. Inside City Limits
	Mary 28a-i notifie	Jirec	MD Montgome	ry	Silv	er Sp							1 🗆 Yes 2 😾 No
	ith the 23a or st be r	ral	10e. Street and Number				10f. Zip Code 20910					zen of What Co ed Stat	,
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		12. Was Decedent Eve Armed Forces?		13. V	Vas Decedent of H	ispanic Or an, Mexica	rigin? (Spe	cifv Yes or No-		14. Race - Ame	rican Indian,
9036	ırs after ural", o	Completed by	1 ☐ Never Married 2 ☐xMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates.	0	1	☐ Yes 2基 No	Specify	<i>r</i> :		S	Specify: Whi	
Maryland 21215-0036	72 hou an "nati Medica	mplet	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)	le completed)	Į.	(Give k	ent's Usual Occup ind of work done ONOT use retired)	ation during mos	st of workir	ng	16b. Kir	nd of Business	Industry
212	ygiene ygiene her tha	Be Co		College (1-4 or 5+)	5+		puter An	alyst	:		U.S.	House	of Rep.
and	be filed ental H ked ot ic even	To B	17. Father's Name (First, Middle, Last) Wilford Aaron San	iders						(First, Middle, a Ann V		,	
lary	should and M is mar aumat		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address (Street						o Code)
e S	and 2: Health em 27 ther tr		Barbara Sanders/ 20a. Method of Disposition	Spouse	20h Dia	1710	Noyes L	ane,					
nor.	age 1 ent of l nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cer	netery, crem	stion (ivame of latory or other place n Cremat			7/2010		eation - City or	Town, State Maryland
Baltimore,	Sermit. F Separtm mportal iny injui		21. Signature of Funeral Service License	e	10146	22.	Name and Addre	ss of Facili	ity	Simple	Trib	ute	
	#D = # 0	Н	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one				1040 Ro					ile, MD	Approximate
44	Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition				rcinoma						Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a c	onseque	nce of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onseque	nce of):							
)	ecuted and	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a c	onseque	nce of):							
20/	te be ex nysiciar ne buria	edical Examiner	L,	d									
200	sertifica Iding pl		IF FEMALE: 23b. Was decedent pregnant 23	3c. If <u>ye</u> s, outcome of	pregnanc	SV.						Od Data of dal	li.
BOX 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?  1  Yes 2  No 9  Unknown	1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal of	death 3 🗌	Ectopic pregnand Other (specify)	у				3d. Date of del Month	Day Year
5.	hat the ed by t detach		Part II. Other significant conditions con		not result	ing in the ur	nderlying cause giv	en in Part	l.	23e. Did to	bacco us	e contribute to	the cause of death?
as, I	quires t en sign ould be	ted by								1 🗆 🕆	Yes 2 □	No 3□P	robably 4 🖾 Unknown
SCOL	law re has be je 2 sho	Completed								24a. Was a		24b. Were aut prior to death?	topsy findings available completion of cause of
ř	in: The ifficate or, pag		25. Was case referred to medical				26 Pi	ace of Des	ath (Check	1 Yes			2 □ No
VIE	nysicia nis cert I direct	To Be	examiner? 1 ☐ Yes 2 🛂 No	ospital: 1	2 🗆 EI	R/Outpatient	Oth				ence 6	X Other (Spec	<sub>ify)</sub> Hospice
DIVISION OF VITAL RECORDS,	ding Pl th. After the funera	cate:	27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation	28a. Date of injury (Month, Day, Y		8b. Time of injury	28c. Injury work M 1 🗆	/ at	2	8d. Describe h			
NISIO	or Atter frer dea irector n by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		e, farm, stre			-	8f. Location (S City or Tow		Number or Rui	ral Route Number,
2	spital or hours a neral D		29a. Certifier 1 XCertifying Physic	cian: To the best of my	/ knowled	lge, death o	ccured at the time	, date and	place, and			manner as sta	ited.
	the Ho hin 24 I the Fu	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	er: On the basis of exar Practioner: To the be	nination a	nd/or investig	gation, in my opinic	on, death o	ccurred at 1	the time, date a	nd place, a	and due to the o	cause(s) and manner stated.
			29b. Signature and title of certifier  J · Kouelec	hou,	mo	>	29c. License		18			signed (Month) $1/2010$	, Day, Year)
	10		30. Name and address of person who cor	(					. 0		J/ 1	1/2010	
			Jocelyne T. Kouato				ersity I	arkw	ay, B	altimo	re, M	D 2121	8
	Stat		NAR 17 201	32 Registrar's	oignatur	San	Ked						

State Registrar Jonathan S.

31. Date filed (M

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

pares

15225 Shady Grove Road, #102 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

Plotsky, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 2010 2:30 P M MATTIF STEVENSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 7228 MAHOGANY DRIVE LANDOVER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. DEC 29 Director 1919 NORTH CAROLINA 90 577**-**32**-**9228 Usual Residence of Decedent 28a-f show 10a, State the Me ical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No PRINCE GEORGE'S LANDOVER ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7228 MAHOGANY DRIVE 20785 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. BLACK 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8TH HOUSEWIFE PRIVATE ker ortant: If item 27 is marked other any riury or other traumatic event, i once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ JAMES ELIZABETH HAWKINS DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a 7228 MAHOGANY DRIVE LANDOVER, MARYLAND 20785 FRANCINE HAYNIE/DGT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/15/2010 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MARYLAND 4 Donation 5 Other (Specify) HARMONY CEMETERY J. B. JENKINS FUNERAL HOME Sign sure of Funeral S vice Lice 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PARKINSON DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month signed by the a d be detached f Yes 2 X No 9 Unknown P.O.1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 24 hours after death.

Funeral Director: After this certificate h 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀 No မ 4 Nursing Home 5 K Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural injury 5 Pending 1 Yes 2 No ☐ Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Gentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Van D48238 MARCH 13, 2010

State Registrar

DHMH 17 Rev 7/2009

Bladensburg Road Colmar Manor, Maryland 20722

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Evans

MAR 1 8 2010

4151

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Kenrick Skerritt 2010 10:24 A<sup>M</sup> March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 11358 Cherry Hill Rd. #104 Beltsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🙀 M 2 🗆 F (Month, Day, Year) 10/25/1944 Country)
Trinidad 65 Director 578-72-0995 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ¥ Yes 2 ☐ No MD Prince Georges Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 20705 11358 Cherry Hill Rd #104 USA · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Parking Enforcement other traumatic event, Be it. Page 1 and 2 should be filed utment of Health and Mental Hyprant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert W. Skerritt Princess Agatha Mapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11358 Cherry Hill Rd #104 Beltsville, MD Lenora Baylor / Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 3/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery Washington, DC Signature of Funeral Try 22. Name and Address of Facility Fort Lincoln Funeral Home jurcus 3401 Bladensburg Rd. 20772 Brentwood, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Respiratory Failure disease or condition <u> Hours</u> Medical resulting in death) Due to (or as a consequence of) Examiner 3 Years Amyotrophic Lateral Sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 No as been signed by the 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy After this certificate has page death? 1 ☐ Yes 2 ☐ No Yes 2 x No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending injury hours after death. neral Director, Aff d filled in by the fur 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examinér: On the basis of examination and/or investigation, in my opinion, usair occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

MAR 1 8 2010

Michael Leibowitz, MD

30. Name and address of person who completed cause of death (Item-23a) (Type, Print)

32. Registrar's Sign

11120 New Hampshire Ave.

29c. License number

D08089

29d. Date signed (Month, Day, Year)

20904

March 16, 2010

Silver Spring, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	faryland		artment of I tificate of I			ental Hy		2 U I U		09963
			Registrar  1. Decedent's Name (First, Midd	lle, Last)		Cer	uncate or i	Jean		2. Date of De	Reg. No. ath		3	. Time of Death
	Physicia Medi		Phyllis Max	ine Shives						Month	a Day	Year 2010		250 PM
đ	Examir		4a. Facility Name (if not institution				4b. City, Town, c				1	County of Deat		
	Funeral	N.	Washington Cou  5. Social Security Number		ge (In yrs. la	st birthday)	Hagers			8. Date of Bir		Vashing		e (State or Foreign
	Director		214-42-2288	1 □ M 2 💢 F		8 Yrs.	Months Days	Hours	Min.	(Month, Da larch	y, Year) 5,194	42 Co	untry)	MD
	nd <b>how</b>	] _	Usual Residence of Decedent  10a. State 10b. Count	у	10c. City	, Town or Loc	ation				_		10d.	Inside City Limits
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	a or 2	Ē	10e. Street and Number		1		10f. Zip Code				10g. Citi	izen of What Co	ountry?	
	ns 23 must	<b>Funeral Director</b>	13777 Orchard				2175					USA		
(0	or iter		11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces arried 1 ☐ Yes 2 🎗	?		Vas Decedent of F Yes, specify Cub	lispanic O an, Mexica	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>		ndian,
21215-0036	ırs afte ıral", LExan	Completed by	3 X Widowed 4 ☐ Divorce	16 Ven Oine	2 110	1	☐ Yes 2 🌠 No	Specify	fy:		] :	Specify: V	√hit	te
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Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Heatin and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relation Ronal L. Shive				g Address (Street 7 Orchard							e)
ē,	1 and of Heal item 3		20a. Method of Disposition			ace of Dispos	sition (Name of	- :	Da Da			cation - City or		State
imo	Page ment c ant: If ury or		1 🏻 Burial 2 □ Cremation 4 □ Donation 5 □ Other		٠ I	· ·	atory or other pla idge Cem		03/29	/2010	Hanc	ock, MD	ı	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. gnature of Funeral Servi	Copy (c)	100°Z		Name and Addre		1.7			n Stree		0-0368
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-	Physician/		Immediate Cause (Final disease or condition	a.	SEP	TIC.	sitocia	2					On	set and Death
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_	icate be executed physician and s the burial-transit	cal E	resulting in death) Last	Due to (or as	a conseque	sice oi).	im		FRC					
3760	ficate   g phys	Medical		d	1. 10	CIACIO	INC	IN F	71/12-0	(104				
x 68	n certification	an/N	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth	of pregnan	cy death 3 🗆	Ectopic pregnan	CV			2	23d. Date of del	livery	
. Box	ne deatl / the atl ched fo	Physician/N	1 Yes 2 No 9 Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of de	eath 5	Other (specify)					Month	Day	Year
P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ρ	Part II. Other significant condit	ions contributing to death	but not resu	lting in the ur	nderlying cause gi	ven in Par	rt I.			se contribute to		
rds	require	eted												y 4 Onknown
Division of Vital Records,	The law cate has l page 2 s	Completed									osy ormed?	prior to death?	comple	findings available etion of cause of
alF	ian; Ti ertificat ctor, p	BeC	25. Was case referred to medica examiner?				26. P	ace of De	eath (Check o	-	2 No	1 ☐ Yes	3 2 L	J No
Ţ	Physic this corral dire	은	1 Yes 2 No	Hospital: 1 Inpat		R/Outpatien		4 □ N				Other (Speci	ify)	
o u	rding l tth. After funer	cate	1 Natural 5 Pend		ay, Year)	injury	28c, Injur worl M 1	yat √? Yes 2.[		d. Describe h	now injury	occurred		
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	n 24 ho	Medical	(Check 2 L Medical	g Physician: To the best o Examiner: On the basis of g Nurse Practioner: To the	examination	and/or investi	gation, in my opini	on, death o	occurred at th	e time, date a	ind place,	and due to the o	cause(s	s) and manner stated.
	To the virthing of the country of th		29b. Signature and title of certific				29c. Licens	e number			29d. Date	e signed (Month	n, Day,	
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_			30. Name and address of person	who completed cause of the trice with the trice wit	,	23a) (Type, Pi	_	V7.	57A1-	(n	1==	T itun	251	s Town My
7	Sta		31. Date filed (Month, Day, Year)			ire		-1/6	_ (1)	. 31)	ت س	1- 01710	101	1000000
	Registr	ar	MAR 31	2010	~ 2	1. 100	Wille							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ VIRGINIA EDITH SNYDER MARCH 22, 2010 Year 3:55 Ам Medical 4c. County of Death WASHINGTON 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner WILLIAMSPORT NURSING HOME WILLIAMSPORT Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 1 F Hours Min 6/17/1921<sup>Year)</sup> 88 9MARY LAND **Director** 213-18-9836 Usual Residence of Decedent 10a State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl WASHINGTON HAGERSTOWN MD 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12304 DELWOOD AVENUE Funeral 21740 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐X No Specify: WHITE Specify: Completed 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
DEPARTMENT STORE (Specify only highest grade completed) other than " Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Lry or other traumatic event, the I SALES CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDITH BLANCHE LINE MORRIS S. PAULSGROVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 E. HILLCREST ROAD APT 2, HAGERSTOWN, MD 21742 STEVE SNYDER/SON Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State ST. PAUL S CEMETERY CLEAR SPRING, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility BROWN\_FUNERAL 327 W. KING ST., MARTINSBURG, Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, RENAL Acure disease or condition resulting in death) WEEK Medical Due to (or as a consequence of Examine Sequentially list conditions if any Lee ling to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last VIRAL GASTRO ENTERITIS Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PUEUMONIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown SOUTH DEMENTIA Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autonsy death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? injury Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33700 MARCH 23 2010 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Ted Howe 154 N. AETIZAN ST WILLIAMSPORT 32. Registrar's Sign State MAR 31 2010

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Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me. 9902.04/14/2010dhb State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joanne R. Walter Month Year 4:44PM March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington medical Center Arunde Burne Anne Glea Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 169-42-7581 1 M 2XCXF Months Days Hours Min (Month, Day, Year, Director 58 Yrs 31 1951 Pennsylvania Αυσ. Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 Baylor Road 23a Funeral 21061 U.S.A. items ? 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò ģ 1 Never Married 2 X Married 1 🗌 Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: White "natural" 3 Widowed 4 Divorced Specify: Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Executive Assistant 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Ferraro Anne McDonald other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Byron Walter/husband 414 Baylor Road Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/2010 | Baltimore, Maryland timore Crematory 21. Signature of Forieral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) ATTOM APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner upoxem Sequentially list conditions. ner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o CERTIFIC attending physician and for use as the burial-transit Exami Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year n signed by the a 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No Yes 2 N Division of Vital Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident (Month, Day, Year) 5 Pending work within 24 hours after death. To the Funeral Director: Al M 1 Tes 2 🗆 No Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 32 yo completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month

th, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 26 2010 MARCH HILMA LEE WALKER 1:55 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2856 HOMETTE PLACE CHARLES WALDORF 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 11-1-1927 **Funeral** 7. Age (In vrs. last birthdav) 1□ M 2□xF Days Hours Min 82 Yrs. 579-32-5258 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD. CHARLES WALDORF 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2865 HOMETTE PLACE 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 ∐Yes 2 Man If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 'natural". the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NAVAL RESEARCH LAB Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) SECRETARY 12th other Thealth and Mental Hy tem 27 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARENCE WAKEFIELD CLOUD item 27 is marked other traumatic ev MARY ELIZABETH CLOUD Pages 1 and 2 should nent of Health and Mer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE WALKER-SON 2865 HOMETTE PLACE WALDORF, MD. 20601 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ME METROPOLITAN CREMATORY 3-27-2010 ALEX., VA. 21. Signature of Funeral Service Licensee MQ0479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Luch PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No page 2 this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: nours after death.

neral Director: After this
y filled in by the funeral di Hospital within 24 hours a completely

State

29a. Certifier

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

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and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland	•	rtment of F			jiene eg. No 0   0	09967		
**	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)	NC	Ab City Town o	r Location of Death	2. Date of Dea Month	Day Yea	0 1.45 PM		
Ì	Examir Funeral Director	ner	5. Social Security Number 6. Sex 1 № M 2 □ F 80	st birthday) Yrs.	If Under 1) Year Months Days	3	8. Date of Birth	wash	irthplace (State or Foreign		
	e Maryland la-f show	ctor	Usual Residence of Decedent  10a. State	Town or Loc	ERSTOWN				10d. Inside City Limits 11 ( es 2 □ No		
	3a or 28	al Director	10e. Street and Number 19800 TRANQUILITY CIRCLE		10f. Zip Code	21742		USA	Country?		
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Exeminer must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Mes 2 ☐ No If Yes, Give Year or Dates:	i i	Vas Decedent of H Yes, specify Cuba □Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHITE		
2121	within ene.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give k life. D	ent's Usual Occup kind of work done IO NOT use retired CIAL WOR	during most of worki d) KER		16b. Kind of Busines WELFARE A (PRIVAT	GENCŸ		
Maryland	be ad o	To Be	17. Father's Name (First, Middle, Last) WILLIAM T. WATSON			18. Mother's Name ELIZAB		Maiden Surname) LKERTS			
	12 grant		19a. Informant's Name/Relationship (Type. Print) STEPHEN LEBAU/ POWER OF ATTORNEY			and Number or Run		r, City or Town, State 209	e, Zip Code)		
Baltimore,	e i i i		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	nce of Dispos metery, crem THSBURG	sition (Name of latory or other plac CREMATORY	<sup>сө)</sup> MARC 2010	Pate 28,	20c. Location - City of SMITHS	BURG, MD		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee Rublet C. Helds	22.	Name and Addre 327 W. KI	NG ST., MAR		RAL HOME, PO WV 25402	BOX 821,		
	Physician /Medical	0	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	tach'	No.	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
	Examiner	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	) H	y perte	ension					
8760,	icate be executed physician and the burial-transit	ical Examine	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d								
O. Box 68	eath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time of decent in the past 2 □ Fetal c 4 □ Pregnant at time	23d. Date of Month	delivery Day Year						
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Vital Records,	ician: The law re certificate has bee ector, page 2 sho	Completed					1 □ Yes	sy prior med? death 2 No 1 □ Y			
of Vit	Physician: r this certific ral director, I	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 E		t 3 □ DOA Oth	26. Place of Deat ner: 4 X Nursing Ho	me 5 ☐ Resid	ience 6 ☐ Other (S	pecify)		
Division of	Attending death. ctor: Afte	Certification: To	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be determined cetermined cetering building, etc. (Specify)	28b. Time of Injury ne, farm, stre		ryat rk? ]Yes 2 ☐ No			Rural Route Number,		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral Director of the Funeral Dire		29a. Certifier (Check only (Ch								
	To the within 2 To the complet	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mo			
			30. Name and address of person who completed cause of death (Item:		Print)	0622 000m, 1	23	312	5/10		
	Sta	ate.	31. Date filed (Month, Day, Year) 32. Registrar's Signatu		agenst	DEUM ( I	-11110	<b>Ψ</b> 1 ( <b>U</b>			
	Regist		MAR 3 1 2010	B	Bar (2)						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Albert R. Adams 0600 A M March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins Baynew Medical Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country)
Maryland 1 XM 2 🗆 F Hours Months **Director** Yrs 216-36-2787 Usual Residence of Decedent or 28a-f show e notifi, d at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21222 USA 6936 Broening Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction 9 years Drywall Finisher it, Page 1 and 2 should be filed wi rtment of Health and Mental Hygie rtant; If item 27 is marked other njury or other traumatic event, <u>t</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Simanski William F. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phoebe Adams wife 6936 Broening Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important; If ite
any injury or ott April 1, 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2010 Signature of Furnal Service Licensee <sup>22. Name and Address of Facility</sup> Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Failure Respiratory disease or condition resulting in death) 18 hours Medical Examiner Due to (or as a consequence of) Preumonia 3 weeks Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam 6 month s the burial-transi -una cancer that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the g 🗌 Unknown cate has been signed by page 2 should be detacl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗆 <u>No</u> 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ပု 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1XNatural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) ligabelt Fetton RES-000

State Registrar

4940 Eastern Avenue Baltimore, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's Signature March 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 **Physician** March 31, S. 3:45 a Margaret Armfield /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Edenwald Towson 8. Date of Birth (Month, Day, Year) June 14, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days 1 □ M 2 □ F Hours Min. Virginia 115-44-5054 92 June Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic event, It would also injury or other traumatic events. 1 ☐ Yes 2 ☑ No Director MD **Baltimore** Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 800 Southerly Road 21286 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Swain Gertrude Thompson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Hahn-daughter 507 Charles Street Ave., Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 4/2/10 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End isease stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dire to for as a nonsectionne off that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a d be detached fi Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2□ Medical Exa 3 CRNF Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

SUSAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

800

R154032

Towson, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year ELIZABETH. ARTHUR MARCH. 27 22.45 PM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL HARFORD HAVRE DE GRACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 7 70 Director 220-54-7349 12/12/1939 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f ehow The Madical Examinar must be notified at 1⊠Yes 2□No Directo Havre de Grace Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 Germany Funeral 5 Locust St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tailor Garment oith and Mental Hygier 27 is marked other till r treumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Anna Hergert Adam August Witzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 le m eny Injury or other treum once. 30 Colonial Circle, North East, MD 21901 Lorna McMillion (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company 3/30/10 West Chester, PA 21. Signature Furnal Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIC ENCESHALOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner ASTITULIC CARDIAC ARROTT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed CONDNALY ANTERT U155A16 Due to (or as a consequence of): by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) o 9□ Unknown ته Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DIABETEI MECLITUS HYPERLIPIABRIA. 1 Yes 2 No 3 Probably 4 Unknown Completed AUTE RENTE FAILURE. STROKE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete hes b irector, page 2 s 24a. Was an autopsy performed? 1 Yes 2 No RENTZ PAILLIE of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Marsing Home 5 | Residence 6 | Other (Specify) Certification: To 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No i Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide hours efter within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 170 121778 MARCH- 29. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAUPORD METTORIAC HOMITAL, HAVING OF CMCG 2107P AUN SWEATTIN 37. Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 1 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 45 per dr., 2902, 04701/2010dhb and Mental Hygiene [ 1997 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Macch Bartholomew AM Behner mec 2010 10:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours 7-17-1928 214-22-2702 81 MARYLAND Director Usual Residence of Decedent show 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director BALTIMORE MD ROSEDALE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 7908 RIVERDALE AVENUE 21237 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: WHITE "natural", Completed 3 Divorced 4 Divorced Year or Dates 1 950 - 52 event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NEW CITY OPTICAL 10 GRINDER Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHRISTOPHER BEHNER MYRTLE (FINNERTY) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTOINETTE BEHNER/WIFE 7908 RIVERDALE AVENUE 21237 ROSEDALE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) SACRED HEART JESUS 3-29-10 DUNDALK, 21. Signature of Juneral Service Licensee 22. Name and Address of Facilit CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, 2123 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, ustenic disease or condition resulting in death) Medical as a consequence of) Examiner eumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 Physician: The certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) Hospice Hospital 1 Tyes 은 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. 29c. License number 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) Battimore State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Fh G902 4/7/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 6 4BRAHAM BROOK PM 0 Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE LOCH RAVEN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Pay, Year) 11-10-1930 1 X M 2 - F Months Hours Min. Yrs. **Director** 219-28-79 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 XYes 2 No MD na Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 408 E. 21st Street 21218 U S items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

XXYes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lord Baltimore Press Elementary/Seconday (0-12) College (1-4 or 5+) Shipping Receiving 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>Nettie Swan</u> Abraham Brooks 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 1321 Church Hill Drive Pikesville, Gloria Eaddy-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o Garrison Forest 1🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 4-7-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March East F/H 22. Name and Address of Facility 21202 1101E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF Physician/ CARGINOMA LIVER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury Due to (or as a consequence of): burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 1 Yes 2 Unknown the Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe VASCULAR ACCIDENT CEREBRO 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Yoursing Home 5 - Residence 6 - Other (Specify) 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meen 30272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

THONASS. MILLEN

APR 01

31. Date filed (Month, Day, Year)

BOULEVARD BALTIMORE MARYLAND 21218

3900 LOCH PAVEN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 14, 2010 Michael Brooks 1400 Fredrick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign **Funeral** Months Days Hours April **Director** 438-94-9583 54 1955 Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits DC Washington 1 🔀 Yes 2 🗌 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5105 F Street, Apt. 104 20019 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates, 1974-75 Specify: Black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Brooks Cleo Woods permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Wallace - Sister 3450 Caesar Drive Algiers, LA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) St. John's Crematory 3 - 23 - 10New Orleans, LA Signature of Funeral Service Licensee 22. Name and Address of Facility Rhodes Funeral Home 1020 Virgil St. 70053 Gretna, art 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) TA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Dusite (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ≥ L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No 2X N 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ※ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 X ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled in Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 J00636XB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Meher Chaudhry, MD

APR 0 1 2010

31. Date filed (Month, Day, Year)

Cheverly, MD

3000 Hospital Drive

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 📗 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2010 March 30, **Physician** Sr. 8:05 PM Nicholas Bressi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Riverview Nursing Center Essex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Day, Year Days | Hours | Min. | September | 19,1933 | Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 M 2 □ F Months 76 Director 214-30-2624 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show treumatic event. The Medical Examiner must be notified at 1 Yes 2 XNo Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21222 USA or items 23a 7359 Edsworth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of deeth and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masonary 10 years Bricklayer 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be Lillian DiFrancesco Archie Bressi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Heelth ar
Importent: If Item 27 Is
any injury or other treu 7359 Edsworth Road, Dundalk, Maryland Josephine Bressi wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 3, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of Jesus Cem. Dundalk, Maryland 2010 21. Signature of Fundal Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Athero Poleratic Cornery avery Hausned Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Winknown was Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28d. Describe how injury occurred After the Hospitei or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) etter 4 Homicide within 24 hours e To the Funerei C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-38754 BASTERN BLVD. M.D. 21221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 1/200

Registrar

709.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of	Marylan		artment of H		lental Hyg	giene	0 00075
1			1 - State Registrar	43		Cei	rtificate of I	Death		Reg. No.	0 00010
П	Physicia		1. Decedent's Name (First, Middle, La L. Virginia Br	,	r				2. Date of Dea Month MARCH	Day Yea	3. Time of Death 7: 25 PM
mar. S.	/Medic Examin		4a. Facility Name (If not institution, gi					Location of Death		4c. County of De	eath
- Japan "			St. AGNE	_ 1	S. TAL	en de est belietbenden d	If Under 1 Year	If Under 24 Hrs.	O Data of Blat		Birthplace (State or Foreign
ı	Funeral Director			Sex 7 1 □ M 2 23 F	. Age (In yrs. 88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 7	Year) 21 M	Country laryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	tor	MD Baltin	nore	Cat	onsvil	1e				1 □Yes 2 😾 No
	r 28a	Director	10e. Street and Number	.010			10f. Zip Code			10g. Citizen of What	Country?
	th wit		139 S. Hilltop H	Road			212	228		US	SA
980	should be filed within 72 hours after death with the Maryland nd Mentla Hygiene. and Merkad Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matte event, the Medical Even in the natified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 □Yes 2 If Yes, Give Year or Dat	es? No	i	Was Decedent of H If Yes, specify Cuba 1 □Yes 2XINo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
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121	within ene. than	Jup	Elementary/Secondary (0-12)	College (1-4	1or 5+)		DO NOT use retired okkeeper	1)		Baltimore Business S	School
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ylar	should be and Menta s marked umatic ev	To B	William Andrew Me	etcalf				Norma E	lizabet	h Bruce	
Š			19a. Informant's Name/Relationship Gloria Davis	(Type. Print) Daughte	er	19b. Mailir	ng Address <i>(Street</i> 5. Hillto	and Number or Rui p Road; C	al Route Numbe atonsvi	r, City or Town, State	e, Zip Code) L 2 2 8
altimore,	of H		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		tate 20b. F	oudon I	esition (Name of matory or other place Park Ceme	tery 3/31	/2010	20c. Location - City Baltimore	, MD
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Line	nsee UU-	MOID	30 1	iuneral H	ome of Ca	tonsvil	re, inc.	wab Witzko , MD 21228
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that car one cause on each	used the deat ch line.	h. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):	c . c 11.	0.0008	E-100	CARDITIS	CANE MONTH
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8760,	ficate be executed physician and s the burlal-transit	cal Ex	resulting in death) Last	Due to (o	r as a conseq	uence of):					
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O. BC	the death certific y the attending p iched for use as	sician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No  9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify)							23d. Date of Month	delivery Day Year
o.	w requires that the de been signed by the should be detached	by Phys	Part II. Other significant conditions	4 4 5				en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
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Records,	2 38 a	Completed	PROSTHETIC	MITR	AL.	UAL			24a. Was a	sy prior	autopsy findings available to completion of cause of
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0	Phys ral dir	 7	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time o	IL S LI DOA	4 🗀 Nursing H		lence 6 Other (5	Specify)
on	th. : Afte	ation	1 Natural 5 Pending 2 Accident investigation	(Month	, Day, Year)	Injury	Worl	ḱ?¯` Yes 2 □ No	200. 200050 1.	on injury occurred	
Division	Il or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place o	f Injury - At ho g, etc. (Speci	Iome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	(Check only 2 Medical Exa	miner: On the bas	sis of examina er stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time,	cause(s) and manne date and place, and	due to the cause(s)
	Vithi Com	M	29b. Signature and title of certifier	000			29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
			> XOTHER	11117			1000	40013	1	MARCH 3	019610
			30. Name and address of person who	completed cause	of death (Iter	n 23a) (Туре,	Print) KROAD,	SUITE	204, (	ATONSUL	onth, Day, Year) 8, 2010 11226
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature /	6-11				
	Registr	ar	APK U	1 2010 P	Census	J. 12.	garke				

DHMH 17 Rev 1/2001

VIRGINIA

Brusitwel LBZ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 8:35AM **Physician** 2010 /Medical Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 07-03-1953 Washington, DC 56 214-60-2974 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location 28a-f show Y Yes 2 No ems 23a or 28a-f sh r must be notified a Upper Marlboro Director MD P.G. 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? U.S.A. 20774 14120 Water Fowl Way Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

★□ Yes 2 □ No 11. Marital Status Specifyblack 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates 9 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) GSA Sollege (1-4 or 5+) ed other than " event, the Med Elementary/Secondary (0-12) Contract Specialist Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Butler is marked Ralph Bryant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14120 Water Fowl Way Upper Marlboro, Md 207/4 Department of Health at Important: If item 27 is any injury or other trau Karen E.V. Byrant/Wife 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 04-08-2010 cheltenham, MD MD. Veteran Ceme. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faciliti Ronald Taylor II 21. Signature of Funeral Service Licenses 21201 108 North Ave Baltimore, MD W. 23d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician and street the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Tectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 □ No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 1 🗌 Yes 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1X Inpatient Other: 4 \( \sum \) Nursing Home 2 No 3 DOA 1 Tyes 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 🗌 Yes 2 🗌 No Director: A id in by the f death 3 Suicide Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2010

**ORIGINAL** 

Barke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 29c, d per dr., g902,0470172010

Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month you)v 2010 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 70 Months Hours MD Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Windson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Place USA Was Deceue.
Armed Forces?
Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 - Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Seconday (0-12) Sollege (1-4 or 5+) Schools Teacher Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norris Morgan tattie Brown 19a. Informant's Name/Rel nship (Type, Print) Quulhter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meadow Mils Road Ownes Milk MD 21117 eghanie L. Dunn-Hunt 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn MD emeter 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vauchn C. Greene Funtral SVS Rangallyan MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been siç page 2 should b Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 24 hours after deam.

• Funeral Director: After this certificate Pleted filled in by the funeral director, pagn 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year, **RES-000** March 24, 2010 erh 2401 Bel veclere Au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a . Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wayne MARC Co1e 10:15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington GLEN BURNIE Medical Center ANNE ARUNDEL 6. Sex 1 M 2 □ F **Funeral** . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) March 20,1956 9. Birthplace (State or Foreign 216-68-9330 Hours 54 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel 1 🗆 Yes 2 ី No Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 128 Foxview Drive 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. β 1 Never Married 2 Married ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural", 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Systems other than Elementary/Seconday (0-12) Expartment of Health and Mental Hygiene. Important: If item 27 is marked out any injury or other examples. College (1-4 or 5+) District Service Manager Associates Global Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John O. Cole Corinne Conaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Bryan Cole /Brother 8245 Glenmar Road Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 2. 1 A Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 2010 Elkridge, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Crneation Services PA 1 2 nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to minediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No After this certificate 1 Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 🗌 No Investigation within 24 hours after deal To the Funeral Director: 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

APK U I

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Deam	2. Date of De	Reg. No. 🗸 🔱	10	3. Time of Death
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	/Medio		4a. Facility Name (If not institution, give street an		one i i	4b. City, Town, o	r Location of Dea		1 29, 20 4c. County		1:54 P <sup>M</sup>
	Examir	ıer	Greater Baltimore		Center	_	wson	ui		altir	more
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hr	8. Date of Bir		9. Birthp	place (State or Foreign
	Director		218-32-6613 <sup>1</sup> 2 <sup>M 2□</sup>	F	75 Yrs.	Months Days	Hours Min	Apr 18	th iv, Year) 1934	Maryl	land
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	vith th	ä	10e. Street and Number			10f. Zip Code	2		10g. Citizen of		
	s 23s	eral	36 Oakridge Court	D	0 40 1	2109			1	U.S.	
	item	-cn	Arme	Decedent Ever in Und Forces?	.5. 13. \	Was Decedent of H f Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ck, White,	can Indian, etc.
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3,0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Evan, item rust to motified at	Be Completed by Funeral Director	15. Decedent's Education	44)	16a. Deced	dent's Usual Occup	ation		16b. Kind of B	usiness/In	dustry
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6	ages ant of t: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f			sition (Name of natory or other plac Serv Corp		1/10		-	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, I'm Medical Evan, i'm 1 west to notified at once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		100	. Name and Addre	45.00			on, M	
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	/Medical		disease or condition resulting in death)  a	e to (or as a conseq		1103					
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Division of Vital Records,	l or Attend after death Director: Jin by the f	Certification: To	4 Homicide determined	lace of Injury - At houilding, etc. (Special	ome, farm, stre	et, factory, office		28f. Location (	Street and Numb vn, State)	er or Rura	al Route Number,
	spital ours neral filled		29a. Certifier 1 ertifying Physician: To	the best of my kno	wledge, death	occurred at the til	me date and plac	e and due to the	cause(s) and m	anner as s	stated
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examiner: On t	he basis of examina manner stated.	ation and/or inv	vestigation, in my o	ppinion, death occ	curred at the time,	date and place,	and due to	o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	,	29d. Date signe	d (Month,	Day, Year)
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_	12		Jeffrey Sternlich.	- MD	6701	N. Cha	vies ST	. TOWSO	n MC	21	204
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0.3 Month 29 ay 5:20 P M 20°TÖ William John Carroll, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth Funeral 1 🔀 M 2 🗆 F Hours Min. Baltimore, MD 1070671965 44 215-54-1416 Director Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Ex-miner must be notified at Director 1 Yes 2 X No Timonium Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 Misty Wood Circle 11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Trucking Diesel Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernadette Zamenski William John Carroll, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Burnside Road, Hampstead MD 21074 Lauren Carroll Wells/ sister 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Dulaney Valley Cem. 04/01/2010 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b director, page 2 sf autopsy performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 - Nursing Home 5 - Residence 6 A Other (Specify) Hospice 2 No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No injury 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide
4 Homicide 6 Could not be within 24 hours after dear To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier , Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) R149194 March 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles , touson, mo 21204 Marian Grant 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 1 per doc 9902 4-1-10 vt
State of Maryland / Department of Health and Mental Hygiene State amend item 1 per doc g902 4 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) Helen Frances Dietz 2. Date of Death 3. Time of Death March Physician Year FRANCES 10:02 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital N/A**Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months 219-38-9509 Yrs MARYLAND 68 JULY 6,1941 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov at notified Director 1X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō be 23a 3025 O'DONNELL STREET Funeral must 21224 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ral", or iten Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NURSING RN other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDMOND J. DIETZ HELEN A. FRANCIS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN DIETZ- BROTHER 506 LOWE ROAD NEW PARK, PA 17352 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 3/27/10 BALTIMORE, MARYLAND Signature of Funeral Service License 22. Name and Address of Facility CHARLES S ZEILER & SON 6224 EASTERN AVENUE BALTIMORE, MD 21224 23a. Part 1, Enter the giser complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart fallure nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician rhabdomyolysi /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate E let be cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as F FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) d by the at 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, g 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page certificate 2 X No 1 🗌 Yes 2 **X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation (Month, Day Year) thours after death.

uneral Director: Afteely filled in by the fur 2 Accident 1 Yes 2 No 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD Res -000 March 25,2010

5

DHMH 17 Rev 1/2001

State

Registrar

parke

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TUM TRAN, MA

MAR 29

31. Date filed (Month, Day, Year)

			Amend #5	Please , per Fh	Type or Pri g902 4/15 State of M	nt in E	Black Ir d / Depa	ndelible In	<mark>k. Ensur</mark> Iealth an	e All Copie d Mental Hy	es Are	Legible	09983	
			For State Registrar			_		tificate of L			Reg. No			
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	Examir	ner	Good S	amart	e street and number)	oital	J	4b. City, Town, o Baltim	ore			c. County of Dea		
	Funeral Director		5. Social Security No. 220 – 96 – 8 Usual Residence of	964	Sex 7. Ag	46	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of B Min. (Month, D 08/20	irth ay, Yea <i>r)</i> /196	3 Ma	thplace (State or Foreign untry) Lyland	
	Aaryland 8a-f shov tified at	Funeral Director	10a. State MD	10b. County Baltim	ore		, Town or Loc sedale	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	a or 2 be no	iQ Is	10e. Street and Num	nber		·		10f. Zip Code			10g. C	itizen of What Co	ountry?	
	th witl ns 23 must	inera		ering Av				21237				U.S.A.		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		12. Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of His Yes, specify Cuba		(Specify Yes or No uerto Rican, etc.)	)-	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	iin 72 hou ie. han "natu	Completed	(Sper	15. Decedent's i cify only highest g anday (0-12)		5+)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)		working	16b. F	Kind of Business	Industry	
2	d with hygien ther t	BeC	12. Father's Name (#				Re	estaurant					Beverage	
and	be file ental F ked o c eve	To E	Carl	Weldon	Dunawa	V			18. Mother's Edna	Name (First, Middle		Surname) Whit	olu.	
~	and 2 should Health and M tem 27 is mar ther traumati		19a. Informant's Na	me/Relationship (	Type, Print)	1	1	iling Address (Street and Number or Rura 24 Evering Avenue,		Rural Route Numb	al Route Number, City or Town, Sta		p Code)	
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disp 1 Derial 2 ( 4 X Donation		Removal from State	ce	ace of Disponentery, crem	sition (Name of natory or other place	e)	Date /30/2010	20c. L	ocation - City or		
Balti	permit. Page Department of Important: If any injury or once,		21. Signature of For	neral Service Licer	see			Name and Addres	ss of Facility	Anatomy	Gift	s Regis		
	hysician/		shock, or hear Immediate Cause (I disease or condition	t failure. List only : Final	nplications that caused one cause on each line	the death.	. Do not ente	r the mode of dyin	g, such as card		ırrest,	Ĭ	Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	ſ	Due to (or as	0.	ence of):	£			1:			
	executed ian and trial-transit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	lying injury	Due to (or as			sī th's						
09	tte be exec hysician ar he byrial-t	<del> </del>	resulting in death) L		Due to (or as	a conseque	ence of):							
. Box 68760	Attending Physician: The law requires that the death certificate be ar death.  Actor: After this certificate has been signed by the attending physici cythe funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medic	IF FEMALE: 23b. Was decedent   in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal	death 3	Ectopic pregnanc	у			23d. Date of de Month	livery Day Year	
ds, P.O.	v requires that t s been signed b should be deta			cant conditions	contributing to death b		ilting in the ui		ren in Part I.	23e. Did			the cause of death?	
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tal	ician: The certificate ector, pag	Be	25. Was case referre examiner?		Hospital:					Check only one)				
Į.	Physi this cral dire	1	1 Yes 2 2 27. Manner of Death		1 Inpati		R/Outpatien	t 3 DOA Othe	4 LJ Nursin	g Home 5 Res			sify)	
o uoi	ending eath. or: After the fune	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investigatio 6 Could not be	(Month, Day	y, Year)	injury	work		28d. Describe	now injur	y occurred		
Division	tal or At is after of al Direct led in by		4 Homicide	determined	28e. Place of Injubulding, etc		ne, farm, stre	et, factory, office		28f. Location City or To			ral Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director. After this certificate completed filled in by the funeral director, pa	Medical	(Check 2 only one) 3	☐ Medical Exam ☐ Certifying Nur	sician: To the best of liner: On the basis of e se Practioner: To the	xamination	and/or investi	gation, in my opinio	n, death occurr	red at the time, date	and place	e, and due to the	cause(s) and manner stated.	
	vitl Co		29b. Signature and t	itle of certifier	elni			29c. License			29d. Da	te signed (Monti	renty-seven,	
			30. Name and addre	ss of person who	0	eath (Item 2	23a) (Type, Pr	rint)	Zaven	Bircl				
	Star Registra	e	31. Date filed (Month	PR 0 1 2	32. Registra		M. A	arked	-1 V C//					
DHA	THE 17 Rev 7/20			<u> </u>			The same							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 0025 2010 ton Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** lowsor it more (51 HOS 8. Date of Birth

(Month, Day, Year) Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Months 1 № M 2 🗆 F -Yrs **Director** Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland notified at Director 1 🗓 🗷 2 🗆 No 28a-f nma 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number must be Funeral 23a 2 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces' Black, White ò þ 1 Never Married 2 Married Yes 2 10 Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than conday (0-12) College (1-4 or 5+) OMMUNI Cection traumatic event, Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 0 ormant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 12 lones zumic Method of Disposition 20b. Place of Disposition (Name of 20c. Location Date - City or Toy Page 1 cemetery, crematory 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spegify) 21. Signature of Funeral Service In 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. Metastoctic adenorarcinames disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes Division of Vital Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 12 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death funeral 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After (Month, Day, Year) 5 Pending work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide determined completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

within 2 To the F

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. P

29c. License number

Sonteur

29d, Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla				d Mental Hyg	giene				
			State Registrar		Cer	tificate of E	Peath		Reg. No.	0 09985			
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	M	FOW			2. Date of Dea Month	28 28	10 00 00 M			
	Examin	er	4a. Facility Name (if not institution, give str			4b. City, Town, or		ath	4c. County of D				
	Funeral		Mandrin Hospice  5. Social Security Number 6. Sex	House 7. Age (In yrs	s. last birthday)	Harv If Under 1 Year	If Under 24 H	rs. 8. Date of Birtl	Anne Arı	Birthplace (State or Foreign			
	Director		220-20-4650	M 2 F 82	Yrs.	Months Days	Hours Mi	n. March 8	, Yell 928	Maryland			
	d tow	_	Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or Loc	ation		-		10d. Inside City Limits			
	arylan a-fsk fied a	ecto	Maryland Baltim		•	onsville				1 ☐ Yes 2 🔀 No			
	he Mi or 28 e noti	D.	10e. Street and Number	ore	Oatt	10f. Zip Code			10g. Citizen of What	Country?			
	with t	Funeral Director	6 August Avenue			212	228	1	United Sta	ates			
	death items			. Was Decedent Ever in I	U.S. 13. V	Vas Decedent of Hi	spanic Origin? (	(Specify Yes or No- erto Rican, etc.)		merican Indian,			
36	after ( I", or xamir	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	I	☐ Yes 2 No			Specify: W	/hite, etc. hite			
8	nours natura ical E	Completed	15. Decedent's Educ		16a, Deced	ent's Usual Occupa	ation		16b. Kind of Busine	ess Industry			
215	in 72 e. nan "r Med	dmc	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	life. Do	kind of work done d O NOT use retired)	_	1	ing				
2	d with ygien her th	0		1	Telep	hone Oper	****		Telephone	Company			
Maryland 21215-0036	oe filed Intal H Ked of	10 B	17. Father's Name (First, Middle, Last) William F. Fowler		lame (First, Middle, I Garner	Maiden Surname)							
Σ	nd Me mark mark		19a. Informant's Name/Relationship (Type	Print)	Edna and Number or F		; City or Town, State,	Zip Code)					
	d 2 skalth a		Brian McFarland/Att	orney					. Marylan				
ore	of He of He of item of other		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ Re	20b					20c. Location - City				
Baltimore,	t. Pag tment tant: tjury c		4 ☐ Donation 5 ☐ Other (Specify)	Ne	w Cathec	sition (Name of natory or other place	ery 20			, Maryland			
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	manda Heast —	on   22	. Name and Addres	s of Facility [v] 8	acnabb Fur	neral Home ville, Mar	e, P.A. cyland 21228			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the decause on each line.				ac or respiratory arre	est,	Approximate Interval Between			
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	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a corrse	squence on.								
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x 687	eath certificat attending ph I for use as th	an/N	200. Was decedent pregnant	. If yes, outcome of preg 1  Live Birth 2  Fe	nancy etal death 3	Ectopic pregnanc	v		23d. Date of				
. Box	ne death / the att ched fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 DONo 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)	•		Month	Day Year			
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lof	ling P	ate:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe ho	ow injury occurred	1) USINCE			
sioi	I or Attendi after death Director: A I in by the fi	Certificate:	Accident Investigation  3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At	home, farm, stre		Yes 2 No	28f. Location (Si	treet and Number or	Rural Route Number,			
Division	ital or urs afte	<u>ခ</u> ြ	4 - Hollicide determined	building, etc. (Spec	ify)			City or Town	n, State)				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) Certifying Physicia   Certifying Physicia   Certifying Nurse F	On the basis of examinat	ion and/or invest	igation, in my opinio	n, death occurre	d at the time, date an	nd place, and due to the	ne cause(s) and manner stated.			
	To the I within 2 To the I comple		29b. Signature and title of certifier	Men	Ay un	29c. License	2143	38	29d. Date signed (Mo	29 2010			
_			30. Name and address of person the som	pleted cause of death (Ite	em 23a) (Type, P	DE KE	NSE T	TIGHWA	y ANN A	POUJMD			
	Stat Registra	_	31. Date filed (Month, Day, Year) APR 0 1 201	32. Registrar's Sign	A. A.	arke				7/401			

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Ye ar 07:52 AM MAR **Physician** 31 2010 GEBHARDT KUTH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWART HOWARD COUNTY GENERAL HOSPITAK CLUMBIA, W.
If Under 1 Year | If Under 24 Hrs. MD Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthdav) 5. Social Security Number 6 Sex **Funeral** Hours Min. MD Months Davs 1 □ M 2X F 91 212-36-3649 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Tyes 2 No 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21044 Funeral 10349 Owen Brown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🖁No Specify: White Saltimore, Maryland 21215-0036 þ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Healthcare Registered Nurse 2 should be filed withi and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen C. Leipold John D. LaVinka ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 10349 Owen Brown Rd. Columbia, MD 21044 Helen Winkles - Sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ellicott City, MD 4/3/2010 Good Shepherd Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 M01044 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebra **Physician** disease or condition resulting in death) Medical Due to (or es a consequence of) Examiner Hi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or es a consequence of) P.O. Box 68760, for use as use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Artery 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performe 2 🗆 No 2 No 1 ☐ Yes 1 Tyes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 ☑ No Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Iniury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie , 2010 31

30 V

State 31. Date filed Wooth, Day

32. Register's Signature

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 201 n Louise Gross 2:15 P. March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Carroll Westminster Carroll Lutheran Village g. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 🖾 F Months 9/16/1919 Director Yrs 216-18-6553 90 Usual Residence of Deceden 28a-f shov 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Carrol1 Westminster 23a or 2 10e. Street and Number 10g. Citizen of What Country? Funeral 250 St. Luke Circle, Suite 711 21158 or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. Armed Force þ 1 Never Married 2 Married Yes 2X No Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 12 Secretary Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of the second of the seco ဂ္ pe Augustus David Condon Viola Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 . Page 1 and 2 sh ment of Health a Department of Health Important: If item 27 Richard Gross/Husband 250 St. Luke Circle, Suite 711, Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 3/31/2010 Winfield, MD Signature of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Part 1 Approximate Interval Be veen On et and veath mediale Cause (Final Physician murrener teas or condition u ing in death) Due to or as a consequence of) Medical Examiner Service of table that man little on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Physician/Medical Division of Vital Records, P.O. Box 68760 SB attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death for in the past 12 months? 1 ☐ Yes 2 K No Month Dav Year Pregnant at time of death the be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? funeral director, page this certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 24 hours after death. Funeral Director, After 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Hospital Medical 1 Certifying Physician: To the best of my kg wledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exa 3 Certifying Nurse Practioner: To the basis settle atton, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated go death occurred at the time, date and place, and due to the cause(s) and manner as stated. ation and/or in within 2 To the I st of my know 29b. Signature and title of certif 29c. License number ath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 31. Date filed (Month Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Blvd. Trailer Finksburg Carroll Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours (Month, Day, 10/05) Director 215-90-3818 45 Country)
Maryland Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Carroll Finksburg 1 🗆 Yes 2 🔀 No 10e. Street and Numbe ò 10f. Zip Code ral", or items 23a o Examiner must be 10g. Citizen of What Country? Funeral 2551 Baltimore Blvd. Trailer #79 21048 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No Black, White, etc. If Yes, Give "natural". Completed 3 Widowed 4 Divorced Yes 2 No Specify: Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hairdresser Cosmetology Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Herbert Lewin Mildred Siske 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Graleski / Sister 1140 T Square Court, Middleburg, FL, 32068 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Anatomy Gifts Registry 03/30/2010 Hanover, Maryland Signature of Funeral Se ice Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Interval Retween Physician/ Onset and Death disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ed by the attending physician and detached for use as the bunal-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Day Month Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det <u>م</u> 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? 2 🗌 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation M 1 Yes 2 🗆 No 6 Could not be Place of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month.

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0°2. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29 Day 2010 Year 2:07 A William В Howard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Drive Glen Burnie Anne Arundel Phyllis 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov • 23 • 1947 212-48-1604 Months Hours Min. **Director** Maryland Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State the Maryland Director Anne Arundel Glen Burnie 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21060 10 Phyllis Drive permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4x Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rthan " Elementary/Seconday (0-12) College (1-4 or 5+) <u>Salesman</u> Auto sales 127 is marked other or traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bernard Howard Sr. Mary Louise Dasch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 4700 Sunbrook Ave. Baltimore MD 21206 Flora Hucht-sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Crownsville Veterans | 4-1-2010 4 Donation 5 Other (Specify) Crownsville MD 2. Name and Address of Facility Ambrose Funeral Home of Lansdown Funeral Service Lice 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) signed by the a ld be detached f 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy perform 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 🗎 U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** MARCH Martin Francis Hennigan, Jr. 2010 3:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSP ITAL BALTIMORE ST Agnes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 15, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 ₹ M 2 ☐ F Months Hours 1924 Pennsylvania Yrs. 85 May 190-14-0456 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examinar mat by nothing at 1 ☐ Yes 2 TNo Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 912 S. Rolling Road Apt 308 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No 1 ☐ Never Married 2 Married  $_{\mathit{Specify}}$ White altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify 3 Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Contracting Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Margaret Schirra Martin F. Hennigan, Sr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Hance Avenue; Linthicum, MD 21090 Patricia Engers Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/6/2010 Glen Burnie, MD Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Signature of Funeral Service Licenses Funeral Home of Catonsville, Inc. MD 21228 <u> 1630 Edmondson Avenue; Catonsville, </u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** ALTERY DAYS -ORDINARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed 1 ☐Yes 2 🗷 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier H-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, 900 CATONAVENCE Baltimore ST Agnes JA6ANA HAJANA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State park Registrar

プログランとのアフロナ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Roland Andrew Hashagen 2010 11:50 PM March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1218 Rock Hill Road Pasadena Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours 88 Director 219-07-9963 28 Marvland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Anne Arundel Pasadena 1 Yes 2 No 10e Street and Number 10f. Zip Code Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

Sant. If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 1218 Rock Hill Road 21122 United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Worker Sparrows Point Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Hashagen B1anche Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 Rock Hill Rd., Pasadena, Maryland 21122 Sandra Kramer/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 4/2/2010 Baltimore, Maryland 0ak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Ave., Baltimore, Maryland 21224 23a. Part 1. Enter the disease. shock, or heart failure. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ercindua Priysician/ a disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Dunita (or as a consequence of) if any leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No certificate 2 🗌 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funer. 1 Natural 5 Pending work' Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death declared at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) maen, 31/2010 & Doctor

Registrar

State

30. Name and address of person who completed cause of death

orl

(Item 23a) (Type, Print)

KITCHIR

8021

32. Registrar's agnature

DHMH 17 Rev 1/2001

State Registrar

		State of Maryland / Dep			•				
	•	_ FOT	ertificate of Death		1. No.2010 19993				
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death				
Physicia /Medica		Margaret Virginia	Huffman	Month March	252010 5:30 A. M				
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death				
		5401 Park Road  5. Social Security Number 6. Sex 7. Age (In vrs. last birthda	Baltimore  If Under 1 Year   If Under 24 Hrs.	O Date of Birth	Anne Arundel				
Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last birthda   1 M 2 日本   96   Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	(ear) 9. Birthplace (State or Foreign Country) Virginia				
ס		Usual Residence of Decedent		11/21/1					
arylar show	5	10a. State 10b. County 10c. City, Town or 1			10d. Inside City Limits 1 ☐ Yes 2 🖺 No				
the M	Director	Maryland Anne Arundel Balti	10f. Zip Code	100	g. Citizen of What Country?				
3a or		5401 Park Road	21225	10	U.S.A.				
death	Funeral		B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,				
after or ite	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	o nican, etc.)	Black, White, etc.				
hours ural",	od by	3 L⁴Widowed 4 ∐ Divorced Year or Dates:	cedent's Usual Occupation	14	Sb. Kind of Business/Industry				
in 72 n "nat	plete	(Specify only highest grade completed) (Giv	re kind of work done during most of work . DO NOT use retired)	king	D. Killa of Business/Industry				
d with giene ir thai	Completed	Flementary/Secondary (3-12)   College (1-40r.5±)	spector		Factory Worker				
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Last)  Clarence Barker		18. Mother's Name (First, Middle, Maiden Surname)					
ould b	မ			nche Rose	·				
d 2 sh th and 7 is m traum		l 1	iling Address <i>(Street and Number or Ru</i> 1 <b>Park</b> Road		City or Town, State, Zip Code) , Maryland 21225				
1 and Healt tem 2 other			position (Name of ematory or other place)		oc. Location - City or Town, State				
Pages ent of nt: If if		I I I I Duria: Z LACTernation 3 I Themoval from State I		26/2010 I	Baltimore, Maryland				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Midical Experiment must be notified at once.	ı	1			cal Service, P.A.				
Depa Impo any I		1 flens albridge	4001 Ritchie High	vay Balti	imore, Maryland 21225				
		23a. Part1. Enter the disease, or complications that cau ed the death. Do not e shock, or heart failure. List only one cause on each in e.	nter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death				
Physician		Immediate Cause (Final disease or condition resulting in death)  End-Stage Alzheime a.	ers Dementia		Offset and Death				
/Medical Examiner		Due to (or as a consequence of):							
	je.	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):							
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.							
te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):							
icate be executed physician and s the burial-transit	dical	d							
eath certific attending p for use as	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery						
death e atter	iciar	in the past 12 months?  1 Dves 2 DNo  4 Pregnant at time of death	B ☐ Ectopic pregnancy □ Other (specify)		Month Day Year				
at the d by the tached	hys	9 Unknown							
es the igne	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?				
v requir been s should	sted			1					
e 2 e	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?				
ician: The certificate h		25. Was case referred to medical	00 81	1 □Yes 2	☑/No 1 ☐ Yes 2 ☐ No				
ysicia is cert directe	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other	th <i>(Check only one)</i>	ce 6 ☐ Other (Specify)				
Attending Physician: or death. ector: After this certific by the funeral director, I	L i	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury Injury	of 28c. Injury at	28d. Describe how					
tendil eath. or: A the fu	catic	2 Accident investigation	M 1 ☐Yes 2 ☐No						
l or Attendi after death. Director: A J in by the fi	Certification; To	4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)				
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	e, and due to the car	use(s) and manner as stated.				
n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, dat	e and place, and due to the cause(s)				
To the I within 2 To the I complet	Ž	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)				
		MsRyupahumiD.	00057465		3   25 / 10				
60		30. Name and address of person who completed cause of death (Item 23a) (Typ. W.S. Rajapa KH MD 2835 Sm 17H AV —	s-703 - Baltimore,	MD. 2120	9.				
State		31. Date filed (Month, Day, Year) 32. This ar's Signature							
Registra		APR 0 1 2010 June S. 4	ball						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State	State of M	larylan	_				and M	ental Hy	giene	€			
			Registrar	1 4)		Cer	tificate	of D	eath			Reg. No	<u>.20</u>	10	00	994
	Physicia Medio		Decedent's Name (First, Middle, Thomas	Liucus		I	ngram	1			2. Date of De March	28	B, 2	ŏio	3. Time of 10:3	f Death 35A M
	Examin		4a. Facility Name (if not institution,						Location of				. County o		7	
	/		Kris Leigh Ass 5. Social Security Number				Seve If Under		Park		0.0.4.00		nne A			
	Funeral Director		406-14-1826	6. Sex 1	92	st birthday) Yrs.	Months	Days	Hours		8. Date of Bir Sept. Da		917	9. Birthp Count	olace (State o	uchy
	how at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	cation			_				1	0d. Inside C	itv Limits
	arylar a-fs fied	ecto	MD Anne A	Arundel	Gle	n Buri	nie									2 <b>X</b> No
	or 28	Ė	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wh	nat Coun	try?	
	with t	Funeral Director	403 Longwood A	venue			21	1061			ł	U.S	.A.			
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 [X]Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates.		11	Vas Decede f Yes, speci	ify Cuban	, Mexican	, Puerto F	oify Yes or No- lican, etc.)		14. Race Black, Specify:	White, e	etc.	
2-0	hour hatu dical	plet		it's Education st grade completed)		16a. Deced	lent's Usua			t of workin	a	16b. K	(ind of Bus	usiness Industry		
7	nin 72 he. han '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DO	O NOT use	retired)	-	CI WOIKIII	9	_		7 0 1		
2	d with lygier ther t	Be C	12			Offic	e Ass	socia					cial	Secu	rity	
and	ntal File	B 子									Surname)					
Ĕ	Special Special only highest grade completed)    College (1-4 or 5+)   College (1-4 or 5+)										- T Ot-	Town, State, Zip Code)				
호 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등										an Road Ocean City MD 21842						
Baltimore, Maryland	Page 1 and ment of Hee ant: If item ury or othe		20a. Method of Disposition 1									wn, State				
Baltir	permit. Page 1 Department of Important: If i any injury or o		4 Donation 5 Other (Specify)  Glen Haven Mem. Park 2010  Glen Burnie, MD  21. Signature of Funeral Service Microscopy  AC 1594  Services PA 1 2nd Ave. SW Glen Burnie, MD 21061													
			23a. Part 1. Enter the disease, or	SUHOXVI		. 126							n bur	nie,		
	Physician/ Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	bra	e Vo		200			clen			1	Approximat Interval Bet Onset and I	ween Death
	Examiner			14 x	Ci	10							unknown			own
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequ	ence oi).									/	
	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events	c. <u>147</u>	$\sim$								unpr			own
	cate be executed physician and s the burial-transit	a E	resulting in death) Last	Due to (or as	a consequ	ence of):										
9	ate be	edical	•	d												
687	certification properties as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date	of delive	erv	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic p Other (spe					23d. Date of delivery  Month Day Year			Year	
0.	that the	by P	Part II. Other significant condition	ns contributing to death b	ut not resu	Ilting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco u	use contrib	ute to the	e cause of d	eath?
S,	uires uld be	edk									1 🗆	Yes 2	No 3	☐ Prob	ably 4 🗌	Unknown
COL	aw req as bee 2 shor	Completed									24a. Was		pri	or to con	sy findings a	
æ	: The cate h										perfo	rmed? 2 No		ath? Yes	2 🗆 No	
ta	ician: sertifi ector	m	25. Was case referred to medical examiner?	Hospital:	_		-	26. Place	ce of Deat			-			nic	
<u>_</u>	Phys this ral dir	2	1 Yes 2 No 27. Manner of Death	1 Inpatie		P/Outpatien		Bc. Injury	4 ∐ Nu		ne 5  Resid			(Specify)	ALF	
n 0	ding th. : After e fune	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investig	(Month, Day		injury	м	work?	es 2 🗆	- 1	d. Describe II	ow injury	y occurred			
SIO	Atter er dea ector by the	Certificate:	3 Suicide 6 Could n	ot be 28e. Place of Inju		ne, farm, stre	et, factory,			_	8f. Location (S			or Rural I	Route Numb	oer,
2	tal or irs afte at Dir led in			building, etc	c. (Specify)			_			City or Tow	n, State)	)			
	ne Hosp in 24 hou he Funer pleted fil	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	xamination	and/or investi	gation, in m	ny opinion	, death oc	curred at t	he time, date a	nd place	, and due to	the cau	se(s) and ma	nner stated.
	To t With To tl		29b. Signature and little of pertifier	+ CDIV	,		29c.	License i		20	- 1	29d. Dat	te signed (/	Month, D	ay, Year)	
			· West	E CRUP				KI	019	95		3	130	12	010	
			30. Name and address of person w	ho completed cause of de	eath (Item	23a) (Type, Pi JP 70	15 DI	617	ALD	R 5	FEG. L	115	141011	M. M	10 210	90
į	Stat Registra	_	31. Date filed (Month, Day, Year) APK U 1 20	TRANDER  Registra	ar's Signa	ire de	No.			,	-/	/		· / · · · ·	=	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year Jones Physician George March 17, 6:45 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Patuxent River Health and Rehab Laurel 8. Date of Birth (Month, Day, Year Feb 22, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days. 1 ₹ M 2 □ F 224-32-0027 1929 Virginia 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ms 23a or 28a-f show must be notified at 1 ☐ Yes 21 No Director MD Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20785 7827 Burnside Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 'natural", or items dical Examiner mu 11, Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 🔀 No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 Is marked other than " r traumatic event, the Mex Elementary/Secondary (0-12) 12 College (1-4or 5+) Law Enforcement Federal Policeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linda Kelley Anderson Jones မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 Arbor Crest Drive, Apt. 14
Charlottesville, VA 22901 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any Injury or other trauonce. Dorothy Palmer / Sister Charlottesville, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 3-21-2010 4 Donation 5 Other (Specify) Charlottesville, VA Riverview Cemetery 22. Name and Address of Facility R. B. McClenny Funeral Service 21. Sig ature of Juneral Service Licensee 600 Henry Avenue, CHarlottesville, VA Villeno enun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) <sub>a.</sub> Failure to Thrive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last b Dementia Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pt for use as tl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No Division or Vital Hospital or Attending Physician; director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural n 24 hours after death.

ne Funeral Director; Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53411 March 18, 2010

State Registrar Jagdish Shesadri,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

14300 Gallant Fox Ln. #210 Bowie, MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** nson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2520 Guilford Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 217-22-9690 83 MARYIAND Director 124/1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Examinar must be invilled at 1 Yes 2 □ No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number U.S.A. GuilFORD 21218 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Pres 2 No 8/1/45 If Yes, Give Year or Dates: 10 15/5/ 1 ☐ Never Married 2 ☐ Married 1∐Yes 21XNo à Specify: BLACK 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) BETHLEHEM Elementary/Secondary (0-12) College (1-4or 5+) stee PERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PEARI JOHNSON DAVIS ပ MANDOTIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12/8 19a. Informant's Name/Relationship (Type. Print) ALLEN L. JOHNSON JR BALTIMORE, MARYLAND FORD AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/2010 DWINGS MILLS, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The DERRICK C. JONES FIH, P.A. ZIZIS Signature of Funeral Service Licenses caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause in terval Between uset and Death Immediate Cause (Final 20 **Physician** rosc disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duc to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? res 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. attending physician for use as the buria led by the a P.0. signed l Records, page 2 should certificate Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of

Maryland 21215-0036

Baltimore,

Certification: To

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State

ical

31. Date filed (Month, Day, Year) APR 01

Registrar

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21<sup>ay</sup> Month O3 2010 7:50a. M Jones Virginia Irene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 2505 Pickwick Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2**X**□ F Country) 215-28-5659 Director 09 02 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Baltimore NA MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21207 U.S.A. 2121 Windsor Garden La Apt D141 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ¥☐ Widowed 4 ☐ Divorced Completed Year or Dates Me lical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event \*\*\*-(Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty Nurse Private Duty 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Emily Dorsey Irvin Gordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Pickwick Road, Baltimore, Md 21207 <u> Vanessa Carroll-Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/10 4 Donation 5 Other (Specify) Arbutus Memorial Arbutus, Md Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 Wabash Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final METASTATIC BLADDER CANCEN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 🗌 Yes 2 🛛 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Daughter's Residence Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ To the only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D28768 29b. Signatu e and title of certifie 29d. Date signed (Month, Day, Year) Cours 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 ONLEANS ST IM-SI. 2 OH ZWI. PITAL 32. Re (strar's Signature State Registrar

DHMH 17 Rev 7/2009

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Physici /Medi			r. Jacksor					March	<sup>Day</sup> 28, 5	2010 2:17	Рм	
Examir	-	4a. Facility Name	1 0-1	e street and number)  A Hospita	4	4b. City, Town, o	r Location of Death		4c. County	of Death Ce George!	5	
uneral irector	!	5. Social Security	Number 6. S		e (In yrs. last birthday 77 Yrs.			B. Date of Birth (Month, Day, uly 25,	Year) 1932	9. Birthplace (State or F S. Country)		
at ow		Usual Residence of 10a. State			10c. City, Town or L	ocation				10d. Inside City		
8a-f sh otifled	ector	MID	P.G.		Upper Mar			10	g. Citizen of V	1 Ves 2	□No	
3a or 2 st be n	I Dir	10e. Street and No.	<sup>umber</sup> xbury Dri	Ve		10f. Zip Code			.S.A.	vnat Country?		
within 7.2 nours after death with the Maryland than "natural", or items 23a or 28a-f show he Me Itcal Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Ma		12. Was Decedent E Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	. Was Decedent of H	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No-	14. Rac	e - American Indian, sk, White, etc. Black		
ges I and a should be bled within 72 hours after death with the marylar ges I and a should be bleden. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Me iteal Examiner must be notified at		(Spe	15. Decedent's Ed	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done	oation during most of working d)	7	16b. Kind of Bu	usiness/Industry		
		Elementary/Sec 12th	condary (0-12)	College (1-4or 5	Super	_	a)	1	N.I.H.			
h and Mental Hygiene. 7 is marked other than "traumatic event, the Med	ToBeC	17. Father's Name ield Jack	e (First, Middle, Last SSON				18. Mother's Name ( Julia Bro					
and < short		Delores	Name/Relationship (			,	and Number or Rural					
Important: If Item 27 i any Injury or other tra		20a. Method of Di	•	Removal from State	MD. Vete	rans Cei	ne. 4-09-	2010cl	nelten	ham,MD		
Important: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of FacilitiRonald Taylor II Funeral Hme.  108 W. North Ave Balto. Md 21210  23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
ysician Medical		23a. Part1. Enter shock, or he Immediate Cause disease or conditi resulting in death	(Final ion	a	indio ox	sespira	tury t	100es		Approximate Interval Betwe Onset and De	en ath	
aminer		Parameters for		b Due to (or as	a consequence of):	ive h	earl [	-alu	n			
ician and burial-transit	Examiner	if any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)	immediate derlying or injury lts	c. Due to (or as	oncer	earl [	meta	astas.				
physicis	edical			<b>d</b>								
ate has been signed by the attending physic bage 2 should be detached for use as the b	an/IM	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2	2 months?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	3 Ectopic pregnancy 5 Other (specify) Month D					ar	
y the attending ched for use as	ysici	9 □ Unknow	/n	Tate it. Other significant contained contained in a						bacco use contribute to the cause of death?		
igned by the be detached	d by Physician/Medical			contributing to death be	ut not resulting in the	underlying cause gi	ven in Part I.					
been signed by the should be detached	þ			contributing to death bi	ut not resulting in the	underlying cause gi	ven in Part I.	1 ☐ Ye	es 2 No		ailable se of	
been signed by the should be detached	Be Completed by	Part II. Other sign 25. Was case refeexaminer?	erred to medical	Hospital:		Ott	26. Place of Death	1  Ye  24a. Was ar autops perform 1  Yes 2	es 2 No 24b. yened? No	3 ☐ Probably 4 ☐ Un  Were autopsy findings av prior to completion of cau death? 1 ☐ Yes 2 ☒ No	ailable se of	
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oearn. ctor: Afler this certificate has been signed by the / the funeral director, page 2 should be detached	To Be Completed by	25. Was case refrequence?  27. Manner of Dec.  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only	erred to medical  No ath 5 Pending investigatio 6 Could not b determined	Hospital: 1 Inpatie  28a. Date of Inju (Month, Da)  e 28e. Place of inju building, etc.	nt 2 ER/Outpating  Year) 28b. Time Injury  At home, farm, so. (Specify)  of my knowledge, deale examination and/or	ent 3 DOA Otion 28c. Inju Wo 1 ctreet, factory, office	26. Place of Death ner: 4□ Nursing Hom ry at rk? ] Yes 2□No 2: ime, date and place, a opinion, death occurre	1 Ye  24a. Was are autops perform 1 Yes 2 (Check only one 5 Reside 8d. Describe how the City or Town and due to the card at the time, described to the card at the time.	es 2 No  ny yes and? No  24b. ned? No  e)  ince 6 Other we injury occur  reel and Numb n, State)  ause(s) and m ate and place,	3 Probably 4 Un  Were autopsy findings ay prior to completion of cau death? 1 Yes 2 No  ner (Specify)  red  per or Rural Route Number anner as stated.	se of	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clementine Karcz Year 11:20 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FutureCare Northpoint Eastpoint Baltimore Co. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Jan. 9,1929 Country) Maryland 1 M 2 F **Director** 217-22-2296 Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Dundalk MD Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 7610 Gum Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ត់ 1 Never Married 2 Married ģ 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White "natural", Specify: Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than C & P Telephone Clerk 12 Years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Kendrejewski Andrew Karcz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2851 Myers Road Seven Valleys, PA Bernadette Vecchioni (Cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Stanislaus Cemetery 4/1/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Sign thre Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 Wise Ave. 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death <sup>°</sup>⊵hysician/ Cardiopulmonas disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** A Theroscle Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner physician and the burial-transit Josep 2 that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical Diabetes Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 10 Month Dav Year page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Highway Severe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate Denzeszy 1 🗌 Yes Yes or Attending Physician: funeral director, 25. Was case referred to medical examine? 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After is completed filled in by the funera 1 Natural 5 Pending work? Investigation
6 Could not be 1 Tes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D D19540 03-29-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville, MD Walkan 12el Suite 204 Woods 8513 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>010</u> Physician/ Month March Mary 29 1:00 PM Krempasanka Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 8. Date of Birth (Month, Day, Yo June 20, Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Year) 1920 Czechoslovakia 1 □ M 2 🕅 F Hours Director 177-24-4468 89 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Timonium 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21093 2300 Dulaney Valley Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: and Mental Hygiene. is marked other than "natural", Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna (Unknown Maiden Name) Petro Osif Lepartment of Health and Important; if item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15903 Irish Ave. Dr. Edward M. Krempasanka/ Monkton, MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April Date 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gethsemane Cemetery 2010 Laureldale, PA 21. Signature of Funeral 22. Name and Address of Facility
Lemmon\_Funeral\_Home\_of\_Dulaney\_Valley Tagle 10 W. Padonia Road Timonium. 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ HINGERS GOTTE Cardiovascular Disease Medical resulting in death) Due o (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death detached 9 Unknown MARY KREMPASANKA MARCH ' signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24a. Was an 24b. Were autopsy findings available performed? this certificate 1 ☐ Yes 2 ☐ No 2 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1- Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 JENNIFER HAUF, CRNP

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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